ARIZONA STATE PLANNING GRANT

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Prepared by the Arizona Health Care Cost Containment System Administration

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Health Resources and Services Administration
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EXECUTIVE SUMMARY

In March 2001, the State of Arizona was the recipient of a $1.16 million State Planning Grant from the Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS). With a subsequent $100,000 supplemental grant in the fall of 2002, and two Continuation grants (2004 and 2005), the State was very fortunate in having access to SPG monies for six years. This grant has lent tremendous support to the State's ongoing effort to expand coverage to the uninsured in Arizona, increasing the State's ability to ensure the provision of affordable and accessible insurance to all Arizonans. The purpose of this report is to provide a comprehensive summary of the State's activities conducted under the HRSA grant from March 2001 through February 2007.[1]

STATE PLANNING GRANT PROJECT GOALS

The SPG project was planned and overseen by the AHCCCS Administration (AHCCCSA), the State's Medicaid agency. The three and half year project consisted of three phases, each with its own distinct project goals:

Phase I. Development of General Plan for Coverage of Uninsured (March 2001 – March 2003)

This initial phase, which consumed most of the grant's resources, included the following project goals:

- Review and compile information on current health care coverage in Arizona.
- Review current approaches/best practices being used by other states.
- Through a nine-member Statewide Health Care Insurance Plan Task Force (Task Force) and with input from a Technical Advisory Committee, develop a General Plan to address coverage of the uninsured.
- Submit to HRSA a report on the results of the SPG activities by March 2002.

Phase II. Development of Specific Coverage Options (April 2003 – August 2004)

Based on the research and recommendations developed in Phase I, this phase focused on further refining the selected coverage options and included the following project goals:

- Develop strategies for expansion of Healthcare Group, an AHCCCSA sponsored program for small businesses and the self-employed, as a primary means for providing accessible/affordable coverage to the uninsured.
- Analyze, develop and recommend additional policy options to enhance health care coverage in Arizona.

- Build ongoing support for recommended coverage options by working with key stakeholder groups such as a reconstituted Statewide Health Care System Task Force.

Phase III Focus on Small Business Coverage through Healthcare Group

Due to severe budget shortfalls, AHCCCSA realistically shifted its focus away from the more global strategies which would require large infusions of state dollars (e.g., state subsidized high risk pool, additional Title XIX/XXI expansions) to strategies which targeted modifications to existing programs as a means to enhance accessibility and affordability (e.g., employer sponsored feasibility study, exploration of options to enhance small group market). To that end, AHCCCSA used two HRSA State Planning Continuation Grant funds to build upon the work already completed with the previous SPG grant monies. The goals of the Continuation Grants were to:

- Assess characteristics and coverage needs of the working uninsured in Arizona.
- Assess HCG's experience (successes and challenges) in attracting and retaining uninsured small employer groups.
- Evaluate utilization patterns and service demands of the newly uninsured
- Develop an in-depth understanding of needs and interests and identify the barriers at the community level that are preventing people from accessing coverage,
- Design linkages among state coverage programs, the business community, private health insurers, health care providers and the public to maximize sharing of information that will increase access to healthcare coverage.
- Plan and design mechanisms that will allow health coverage information and applications to be initiated at any point along the continuum

DATA COLLECTION

The most significant collection of data primarily occurred during Phase I and was targeted at gaining an in-depth understanding of the current state of health care coverage and who the uninsured were in Arizona. AHCCCSA relied on the analysis of secondary quantitative national and state-specific data using sources such as the Current Population Survey, the Medical Expenditure Panel Survey, state surveys, and state agency data reports. Additionally, extensive qualitative information regarding coverage issues and current approaches and best practices was obtained through literature reviews and discussions with staff from other state programs and other health care experts.

For purposes of developing the selected policy options during Phase II, additional secondary data was sought and the baseline data from Phase I was continually updated. However, the secondary data often did not provide the level of detail needed to make well informed policy decisions, especially as it related to understanding the characteristics of small size firms not offering insurance. To supplement the limited quantitative data, AHCCCSA gathered qualitative data through a series of different stakeholder interviews (rural self-insured employers, rural providers and small size business groups interested in Healthcare Group). In Phase III, surveys and focus

groups were conducted to specifically address the working uninsured and small businesses. In addition, a literature study was performed to assess the usage patterns of the newly insured.

DEVELOPMENT OF POLICY OPTIONS TO INCREASE COVERAGE

A key component of the project was the education of policymakers through the synthesis of information, collection of data, and preparation of briefing papers and formal presentations. In addition to reports on health care coverage in Arizona, over a dozen different policy papers were prepared in Phase I by expert consultants on a myriad of topics, e.g. high-risk pools, international approaches, and rural initiatives. These papers were reviewed and discussed by the Task Force and played an important role in the establishment of a set of guiding principles and the development of the General Plan. Additional input on coverage options was also obtained from the Technical Advisory Committee and through public testimony by key stakeholder groups at Task Force meetings.

In December 2002, the Task Force adopted a General Plan that targeted four basic strategies:

- Narrow the gap between existing public and private health coverage programs.
- Restructure current state employee and retiree health care coverage programs.
- Enhance existing public supported programs.
- Improve the rural health care infrastructure through a variety of strategies including development of a plan to more effectively coordinate current rural health care resources and programs.

In developing this plan, the Task Force recognized that any expansion options that required state funds would not be feasible during the grant period, and that a concerted effort would need to be made to maintain the recent coverage expansions such as 100% FPL and parents of Medicaid/SCHIP children.

During Phase II of the project, AHCCCSA continued to refine and/or implement strategies that supported the coverage options set forth in the General Plan. Two options that were a specific focus of SPG project were:

- Healthcare Group, a state-operated insurance plan for small businesses. In addition to modifications made as a result of Task Force recommendations in Phase I, further enhancements were needed if Healthcare Group was to become a viable insurance option for the uninsured. To accomplish this, a business plan was developed, analysis of the current HCG program and health care insurance marketplace was conducted and meetings were held with various interest groups to discuss proposed product designs and issues of affordability.

- Premium Assistance Program, a public-private coverage program for Title XIX/XXI working families with access to employer-sponsored coverage. A feasibility study identified some serious limitations with this option due to federal regulations and restrictions. AHCCCSA's early attempts for approval of such a program were not

successful. However, in its recent waiver approval, the Centers for Medicare and Medicaid have included a requirement that the agency implement an Employer Sponsored Initiative.

Phase III Focus on Small Business Coverage through Healthcare Group

Due to severe budget shortfalls, AHCCCSA shifted its focus to strategies to enhance access to coverage for employees in the small group market, particularly Healthcare Group. Local information on characteristics of the uninsured working in small businesses, barriers to offering and purchasing coverage, and reasons for choosing and retaining coverage through HCG. Literature reviews were conducted on available coverage and usage patterns of the newly insured. Results showed that there are some differences among the regions of the state that have an impact on purchasing coverage and that there is not a one-size-fits-all solution.

RECOMMENDATIONS TO OTHER STATES AND FEDERAL GOVERNMENT

AHCCCSA found the project organizational structure to be very effective for supporting both the original grant and two continuation grants by allowing for active legislative involvement as well as valuable input from key stakeholders and health care experts. In Phase I, due to the complex nature of the subject matter, education of the members of an official legislative Task Force as well as the public proved to be a critical component for developing the framework for future decisions regarding coverage strategies. To support this effort in Phase I, AHCCCSA was able to effectively draw from secondary data and information available nationally and locally, avoiding a state specific data collection effort which can be both costly and time consuming. However, with the further refinement of coverage options, the ability to make informed decisions on specific design components and implementation strategies became dependent on gathering specific primary data, which was accomplished during Phase III for one of the recommendations through a series of surveys and focus groups.

The Federal Government must work in close partnership with the states to address the issue of the uninsured. To support the states in their efforts to expand coverage, the Federal Government should:

- Allow states more flexibility in the design and operation of Medicaid and SCHIP.
- Provide federal financial support for coverage expansions.
- Expand the level of state specific information collected by the federal government.
- Continue to fund state research on the uninsured.
- Support phase-in approaches as a realistic method for expanding coverage to the uninsured.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

This section provides an overview of how the Arizona Health Care Cost Containment System Administration (AHCCCSA) approached the issue of studying the uninsured and summarizes the resulting baseline information on the uninsured in Arizona.

APPROACH TO STUDYING UNINSURED

Phase I: Development of General Plan for Coverage of Uninsured

In order to develop an understanding of the uninsured in Arizona, AHCCCSA, decided initially to rely on secondary data instead of primary data collected via a special statewide survey or through focus groups. Despite certain data limitations (e.g., lack of county level data), it was felt reliance on secondary data sources (e.g., the Current Population Survey, the Medical Expenditure Panel Survey) would provide the necessary information to allow policymakers to develop a general plan for addressing health care coverage in Arizona. AHCCCSA also planned to use national studies and other states' data surveys to support and enhance the secondary data collected as many study findings show fairly consistent patterns in terms of health coverage demography and coverage issues. The high cost and long length of time were key factors in opting not to undertake the collection of primary data. AHCCCSA wanted to also be able to use State Planning Grant (SPG) monies for the gathering of information on other states' experiences, development of educational materials on health coverage issues and analysis of proposed coverage options.

AHCCCSA contracted with the University of Arizona, College of Public Health, Rural Health Office, Southwest Border Rural Health Research Center (referred to as RHO) to collect and analyze information on:

- Population characteristics and employer composition at both the State and county-level.
- Available health care coverage options in Arizona.
- Characteristics of Arizona's uninsured population.

This effort resulted in three documents - *Health Care Coverage in Arizona: An Overview, Health Care Coverage in Arizona: Data Book* and *Health Care Coverage in Arizona: Full Assessment*. AHCCCSA also contracted with Mercer, Inc. to develop a policy issue paper on key uninsured sub-populations in Arizona. In *Faces of the Uninsured and State Strategies to Meet Their Needs* Mercer identified four (4) key uninsured sub-population groups (i.e., low-income uninsured, working uninsured, rural uninsured, ethnic uninsured) that due to their size merited a closer look by policymakers as they craft solutions to health coverage. These reports were shared and discussed with the Statewide Health Care Insurance Plan Task Force and the Technical Advisory Committee.[2]

The study approach adopted for Phase I of the project proved to be successful in that the State was able to achieve its initial project goals: educating policymakers about coverage issues and the uninsured in Arizona and facilitating the development of a General Plan for the coverage of the uninsured in Arizona.

Phase II. Development of Specific Coverage Options

Although AHCCCSA believes it was the correct decision to use secondary data collection during Phase I of the project, this same approach proved not to be as useful in the subsequent development of specific coverage options. For purposes of developing the selected policy options for coverage expansion, additional secondary data was sought and the baseline data was continually updated. However the secondary data simply was not able to provide the level of detail that was needed to make well-informed decisions as to how best to design and implement agreed upon coverage strategies. For example, in determining the best rural counties to implement a premium assistance pilot program, there was no available data on the number of uninsured in each county and so "other factors" often closely tied to the number of uninsured were examined instead (e.g., % of low-income persons in each county). Trying to develop small group products for low-income individuals proved to be more of a challenge as there was limited information available on the characteristics of the working uninsured employed at small size firms at either a state level or regional/county level.

For Phase II, AHCCCSA believes it would have been more beneficial for the State to engage in some primary data collection. Since the State was able to more clearly define the avenues it wanted to pursue in terms of coverage expansion, primary data collection efforts could be more effectively targeted. Unfortunately, resources were not available to pursue this type of activity during this phase.

Phase III Focus on Small Business Coverage through Healthcare Group

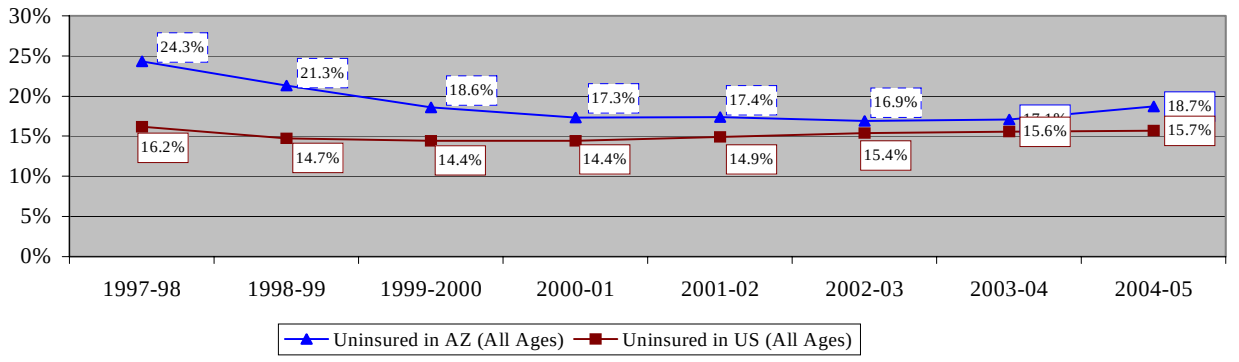
Due to severe budget shortfalls, AHCCCSA realistically shifted its focus away from the more global strategies which would require infusions of state dollars (e.g., state subsidized high risk pool, additional Title XIX/XXI expansions) to strategies which targeted modifications to existing programs as a means to enhance accessibility and affordability (e.g., employer sponsored feasibility study, exploration of options to enhance small group market). A series of surveys and focus groups were conducted to collect more local information on demographics of the uninsured who work in small businesses, real and perceived barriers to offering and purchasing coverage, and reasons for choosing and retaining coverage through HCG. Literature reviews were conducted to 1) identify current and comprehensive data and coverage partners, and 2) to assess usage patterns of the newly insured to determine the likely impact on HCG as more individuals became insured through its coverage products.

DESCRIPTION OF THE UNINSURED IN ARIZONA

Overall Level of Uninsurance

According to the U.S. Census Bureau 2005 Current Population Report, Arizona's overall rate of uninsurance is 18.7%[3], representing over one million Arizonans. After decreasing substantially between 1998 and 2000, the number of uninsured in Arizona for all ages has been increasing while the percentage of total uninsured in the U.S. remained relatively stable (see Table 1). Arizona was one of eight states, whose proportion of people without coverage rose between 2003-2004 and 2004-2005. Relative to other states, Arizona's ranking has also deteriorated from having the tenth highest number of uninsured in 2002-2003 to now having the fourth worst record. The RHO attributed the sharp improvement beginning in 1998 to the increase in employer-based health insurance driven by the State's strong economy and the variety of strategies employed by the State to increase both private and public health care coverage. While the State continued to expand public coverage after 2000, these efforts may have been somewhat mitigated by Arizona's rapid population growth, the increase cost of health insurance and the lower percentage of private sector firms offering health insurance.

Table 1: Uninsured Population in US and Arizona: 1998-2005



General Characteristics of Uninsured

Some of the key characteristics defining Arizona's uninsured population are described below. The data reported in the September 2004 *Arizona State Planning Grant: Final Report to the Secretary of the U.S. Department of Health and Human Services* has been updated for purposes of this section, using pooled 2004 – 2005 Current Population Survey (CPS) data from the Kaiser Family Foundation State Health Facts Online. Any significant changes in the data from that collected initially and/or reported in the September 2004 report are noted.

- Income: Non-elderly individuals (ages 0-65) with income below 200% of FPL were more likely to be uninsured than higher income persons (35% vs. uninsured rate of 12% for those with income at or above 200% of FPL). Sixty-eight percent of the non-elderly

uninsured resided in family units with incomes below 200% of FPL (previously reported at 74% in 1997-1999 and 67% in 2001-2002) and 36% of the non-elderly uninsured had incomes below 100% of FPL.

- Age: Among the non-elderly uninsured, one-fourth were children. The proportion of non-elderly uninsured who were children decreased from 29% in 2001-2002 to 25% in 2004-2005. Overall, children had a lower rate of uninsured than adults 19 to 64 years of age (16% vs. 24% in 2004-2005). Those ages 18 to 24 were more likely to be uninsured than any other non-elderly age group. The pre-Medicare age group (i.e., 55-64) that was initially a focus of policymakers was found to represent only 7% of the uninsured and had the lowest rate of uninsured among the age bands.[4]

- Gender: Mirroring closely the U.S. non-elderly population, a larger proportion of males (54%) than females (46%) made-up the non-elderly uninsured population in Arizona. This proportion has remained constant.

- Family Composition: In 2004-2005, children (25%) and non-elderly adult parents (28%) made up 53% of the uninsured non-elderly population. Non-elderly adults without dependent children represented 47% of the uninsured non-elderly population.

- Health Status: While specific data on the health status of the uninsured in Arizona was not collected, several recent reports lend support to the contention Arizona's uninsured are likely to have poorer health status due to their limited access to health services. The 1999-2000 National Health Interview Survey data found that in the Phoenix Metropolitan Area, 31.1% of the population below 200% of FPL had no usual source of care with 40.4% having no physician visit in the past year.[5] The Ann E. Casey Foundation's Kids Count 2006 Data book ranked Arizona 41st in the overall well-being of its children.[6] This ranking took into consideration such factors as mortality, family composition, adequacy of income and educational attainment. In addition, the 2006 United Health Foundation's composite index of states ranked Arizona 34th in the nation in terms of its overall health status, taking into consideration personal behaviors (e.g., prevalence of obesity), community environment (e.g., violent crime), public and health policy (e.g., lack of health insurance) and health outcome (e.g., mortality, disease prevalence).[7]

- Employment Status: The majority of the non-elderly uninsured in Arizona continued to be "working uninsured." Seventy-two percent of the uninsured were in a family unit with at least one full-time worker and 9% were in a family unit with at least one part-time worker.

- Availability of Private Coverage (including offered but not accepted). Specific information on the number of uninsured who had access to private coverage was not collected. Between 2001-2002 and 2004-2005 there has been a substantial drop in the number of Arizonans who have employer-based coverage (53% to 46%). Both the percentage of employees working for private firms offering coverage as well as the take-up rate by employees has declined. In 2004, 83.9% of Arizona employees worked for private sector establishments offering health insurance with 68.9% of them eligible for

health insurance; and of those eligible, 78.3% had enrolled in coverage.[8] The rate of employer-based coverage was much lower when examined by key drivers of insurance: 23% of the non-elderly with incomes below 200% of FPL had employer coverage, 34% of Hispanics had employer-based coverage, and 23% of part-time workers had employer-based coverage. Mercer's report found uninsurance rates in Arizona increased as firm size decreased (e.g., 45% uninsurance rate for firms of less than 10 employees to 19% for firms of 1,000 or more employees).[9]

- Availability of Public Coverage: Specific information on the number of uninsured who had access to public coverage but were not enrolled was not collected. The percentage of Arizonans on AHCCCS today has stabilized at 17%, with the percentage nearly doubling (primarily due to eligibility expansion) since 1998 when it was at 9%. During the Technical Advisory Committee deliberations, Mercer estimated 50% of the current uninsured population could be covered through public-funded programs if they applied.[10]

- Race/Ethnicity: A disproportionate number of uninsured were Hispanics who, while comprising 28.5% of the total State population in 2005,[11] represented over half of Arizona's non-elderly uninsured (54%). Additionally the rate of uninsured was highest among non-elderly Hispanics (34%) than other racial/ethnic groups in the State e.g., White at 14%.[12] Mercer noted that there was a lack of detailed uninsurance data on the Hispanic uninsured in Arizona but looking at national data indicates that low-income is a key driver affecting the Hispanic uninsured with many working for small size employers who do not offer health care benefits.

- Immigration Status: Specific information on the immigration status of the uninsured was not collected. Not surprising, as a border state, Arizona has the fifth highest number of unauthorized migrants in the U.S. which was estimated to be between 400,000 and 450,000 based on the March 2005 CPS data.[13] The Kaiser Family Foundation reported that nationally between 42% and 51% of non-citizens lack health coverage compared to 15% of native citizens.[14]

- Geographic Location: In 2005, the U.S. Census Bureau estimated that 81% of Arizona's population resided in the two largest metropolitan areas of the State (i.e., Phoenix, Tucson). Similar to national trends, RHO found rural residents (27.2%) in Arizona were uninsured at a higher rate than urban residents (23.9%) in 1999. While specific data on the number of uninsured by counties was not available, AHCCCSA examined key drivers of uninsurance and found rural counties in Arizona often had higher unemployment rates with a higher percentage of low-income residents and a lower average median family income. The Mercer issue brief *Initiatives to Improve Access to Rural Health Care Services* noted that rural uninsured tended to be employed by small-employers, reside in households with at least one full-time worker, are older, younger and poorer and have fewer provider network choices.

- Duration of Uninsurance: Specific information on the duration Arizonans were uninsured was not collected. Nationally, 31.2% of the non-elderly population were uninsured for at least one month during 2003 and 2004, 10.3% were uninsured for the entire two-year

period (2003 and 2004) and 6.6% were uninsured for the entire four-year period of 2001 through 2004.[15]

Key Uninsured Sub-Populations

The Mercer policy issue paper, *Faces of the Uninsured and State Strategies to Meet Their Needs* was invaluable in demonstrating how the uninsured population is not a single, homogeneous population but is comprised of a number of smaller sub-populations, formed by several key drivers of uninsurance which include age, employment (status and firm size), income (relative to poverty level), ethnicity and geography (urban vs. rural) including:

- Low-Income Uninsured, especially low-income uninsured children and their parents.
- Ethnic Uninsured, especially low-income Hispanics uninsured.
- Working Uninsured, especially working uninsured in small size firms.
- Rural Uninsured, especially rural low-income uninsured children and their parents.

This paper, along with the information compiled by RHO was critical in helping to guide policymakers' efforts in selecting coverage expansion approaches to be included in the General Plan. In addition to supporting public expansion efforts targeted at the low-income uninsured, the General Plan recommended specific strategies targeted at the working uninsured in small size firms and the rural uninsured.

In addition to the four groups set forth by Mercer, policymakers also expressed interest in two other sub-populations:

- Initially, the Statewide Health Care Insurance Plan Task Force identified the uninsured pre-retirement group as a sub-population they were concerned about due to constituent inquiries. This group became of less interest to policymakers after Mercer presented information to the Task Force members showing that Arizonans ages 45 to 64, while representing 19% of the non-elderly uninsured population in Arizona, generally had higher incomes than the Arizona population as a whole.
- The Technical Advisory Committee felt it was important to focus on the sub-population of uninsured individuals who were eligible for public funded programs but were not enrolled. As a result, the need for outreach to eligibles was included in the plan.

Working Uninsured in Small Firms – 2006 Survey

Subsequent to the original State Planning Grant, two Continuation Grants (2004 and 2005) were directed at the working uninsured, especially those in small size firms. A number of organizations have reported on the uninsured at a state level, but little reliable information is available at a county level. Arizona, unlike other states, has a vastly disparate geography and population. Aside from its two major urban centers (Phoenix and Tucson), the remainder of the state is either rural (predominately the southern and north western counties) or frontier (north eastern and eastern counties).

To develop health plans and insurance options that are attractive and affordable to small business, it is necessary to understand the characteristics of small business employees in each of the three geographic areas. To aid in this analysis, HCG developed a survey instrument to measure the following factors:

- Employer characteristics
- Previous health insurance history
- Current health insurance status
- Access to health care services
- Familiarity with the health care system
- Perceptions of the health care system
- Attitudes towards health insurance
- Self-reported health status
- Personal and household demographics.

The survey was available online and in written format in English and Spanish. Four hundred and seventy-one completed surveys were received either online or mailed back over the survey period, representing a margin of error of 4.6 percent. Upon analysis, the survey of the working uninsured in small businesses showed that there was little difference among counties in the characteristics measured. Following are the key findings:

Personal & Household Demographics

- The average age of respondents statewide was between 50 and 64 years, although the average age of respondents from Coconino County was between 30 and 39 years. Most respondents were female (65%). Over half of respondents reported their race as white (68%) followed by Hispanic (26%). African Americans represented only 3% of responses. Race varied by county – Hispanics and Native Americans represented the majority of responses in Coconino (56% and 15%, respectively, versus 18% whites.)

- The most common occupation among respondents was construction (14%) followed by professional and technical services (13%), medical and social services (12%), and food services (8%). Approximately three quarters of respondents (77%) had less than a 4-year college degree, of which 29% completed high school or GED and 9% never finished high school.

- Twenty-six percent (26%) of respondents reported a single household, 34% a 2-person household, 14% 3-person, and 25% 4 or more person. Results differed significantly by county. Respondents in Coconino County were more likely to live in households with 4 or more persons (12% 1-person, 24% 2-person, 42% 4 or more persons) compared to Maricopa (25%, 36%, and 23%) and Pima (33%, 29%, and 25%).

- Personal income of respondents was skewed towards lower wages. Over half (57%) of respondents reported a personal annual income of $20,000 or less, with 25% of these

earning $10,000 or less. Overall, 88% of respondents reported incomes of less than $40,000 per year.

Employer and Employment Characteristics

- Almost three quarters (72%) of respondents reported working full-time, with full-time defined as 32-hours or more per week. Twenty-two percent (22%) of respondents reported being sole proprietors, and 35% reported working for an employer with between 2 and 10 employees. Overall, 78% of respondents reported working for a small business (with 50 or fewer employees).

- Statewide, the average length of employment was between 1 and 3 years. Coconino County respondents were more than twice as likely to have been employed 6 months or less (39% for Coconino versus 13% for Maricopa and 14% for Pima.)

- Half (55%) the respondents reported being a regular employee (as opposed to a temporary or seasonal employee), and 22% reported either owning or having an owners stake in the business. Coconino and Pima county respondents were less likely to be a sole proprietor (9% and 12%, respectively, versus 24% in Maricopa).

- Respondents reported only 28% of employers offered health insurance to their employees, the majority (80%) of these employers having 50 or more employees. Of these employers, over half (55%) paid some portion of their employee's premiums, 14% paid all the premium, and 14% paid none of the premium (i.e., premium cost was passed on to employees). For dependent coverage, 61% of employers paid nothing towards coverage of dependents, 35% paid a portion of dependent coverage, and 3% paid all the costs of covering dependents.

- Employers in Coconino and Pima counties were more likely to offer health insurance to their employees (39% and 32%, respectively, versus 25% in Maricopa).

- Since a requirement to take this survey was being employed and uninsured, when respondents who worked for employers who offered health insurance were asked why they were not enrolled in the program, 40% reported not being eligible for coverage, 12% reported being eligible but in a waiting period, and 31% reported being eligible but not able to afford their portion of the premiums. These results differed significantly in Coconino, where 8% of respondents reported not being eligible and 43% reported being eligible but in a waiting period.

Previous and Current Health Insurance History

- When respondents were asked how long they had been without health insurance, 34% reported being uninsured for five years or more. Twenty-five percent (25%) reported being uninsured for a year or less and 50% for three or more years. There was no significant difference among counties.

- When respondents were asked if they had health insurance for any part of the previous calendar year, 33% of respondents said yes. Forty percent (40%) of respondents statewide reported being insured through their employer, and 25% insured through AHCCCS (Medicaid). Results differed significantly among counties, with over 60% of Coconino respondents reporting insurance through their employer compared to 31% in Maricopa and 42% in Pima. Maricopa respondents were much more likely to have had purchase individual or family commercial insurance (29% versus 18% statewide.)

- Over half (58%) of respondents reported living in a household with another insured adult, and 26% reported living in a household with an uninsured child (or children) under the age of 18. Respondents in Coconino County were almost twice as likely to report living in a household with an uninsured child (45%).

- Over three quarters of respondents (79%) reported looking for health insurance on the commercial market over the previous calendar year, 30% seeking the assistance of a broker. Of these individuals, 16% said they were denied coverage because of their existing medical condition (or the condition of someone in their family) and 80% said they could find coverage but could not afford the premiums.

Access and Barriers to Health Care Services

- Half of respondents (55%) reported having a regular doctor or medical home. Eighteen percent (18%) reported using an Emergency Room as their primary source of medical care - respondents in Maricopa up to three times as likely to use an Emergency Room as respondents in Pima and Cochise (24% in Maricopa versus 8% in Pima and 15% in Coconino).

- When asked if they ever needed care, treatment or medication but when without because they could not afford to pay, over half (56%) responded yes. Of these respondents, 36% reported losing days from work, 37% reported getting sicker and 21% reported getting so ill they went to an Emergency Room.

- To pay for necessary medical care, treatment, or medications, 48% of respondents reported having to lower their quality of life, 28% had to avoid paying for basic living costs (such as power, heat, food and rent), 36% used credit cards, and 33% had to borrow money. When asked how much they had to pay out-of-pocket for medical care, treatment or medications in the previous calendar year, 30% said between $100 and $500, 19% between $500 and $1000, and 29% $1000 or more.

Utilization and Self-Reported Health Status

- When asked about their current health status, results varied depending on if the respondent was an employee or owner of the business. Business owners consistently reported their health status as better than employees: 59% of owners reported their health as very good to excellent compared to 45% for employees. Overall, 87% of owners and 75% of employees said their health was good or better. When asked if their health status

was the same or better than the previous calendar year, 86% of both owners and employees said yes.

- Forty-eight percent (48%) of respondents said they had a serious or chronic medical condition that required either regular visits to their doctor (79%), regular treatment (69%) or regular medication (91%). Surprisingly, over a third (34%) of respondents reported having a check-up with a physician in the previous calendar year. Respondents in Maricopa County were less likely to have had a check-up within the last year than respondents in Pima and Coconino (26% versus 41% and 44%). Statewide, 25% of respondents reported not having seen a doctor in five or more years.

- Twelve percent (12%) of respondents reported getting medical care in Mexico during the previous calendar year. The majority of these respondents (75%) lived in southern Arizona (Pima, Yuma, Santa Cruz, and Cochise counties).

Attitudes and Perceptions of the Healthcare System

- Ninety-three percent (93%) of respondents said having health insurance was very important. When asked how health insurance premiums should be calculated, 50% said it should be based on how much a person earns (i.e., means tested), 29% said everyone should pay the same, 13% said premiums should be based on a persons utilization, 6% said premiums should be based on age and sex alone (i.e., community rated), and only 2% said premiums should be based on a persons health status (i.e., underwriting).

- When given a laundry list of medical services and asked to indicate which were the most important for health insurance to cover, respondents top six choices were Emergencies (89%), Preventive Care (86%), Hospital Care (82%), Doctor Visits (82%), Lab Tests (80%), and Drugs (79%). Surprisingly, the results for business owners differed from employees in two of these categories – owners put less value on Preventive Care (69% for owners versus 88% for employees) and Doctor Visits (69% for owners versus 85% for employees.)

- When asked how much they would expect to pay per month for health insurance that would cover their top rated services (i.e., the six services listed above), 40% said less than $100 and another 30% said between $100 and $200. There was no significant difference between the responses of owners and employees.

- Respondents were then asked to indicate their level of agreement with two statements about the uninsured. When asked if doctors, hospitals and medical staff treat people without health insurance the same as people with health insurance, 75% of respondents agreed with 30% strongly agreeing. When asked if people without health insurance get a lower quality of care or less treatment choices than people with health insurance, 80% of respondents agreed with 44% (over half) strongly agreeing.

Survey Conclusions

Surveying the working uninsured is difficult because this population is not easily defined. The working uninsured cross all demographic and economic divides, and as such are not easily reached through standard surveying technique. Healthcare Group found that media coverage was a useful tool to reach this population, particularly print and radio. Direct mail also proved useful.

Healthcare Group was pleased with both the response to the survey and the results that were collected. Historically, little information was known about the working uninsured at a County level, and although the results of this survey did not address the differences between all counties (because of insufficient response rate), it did address some of the major differences between Arizona's three largest cities: Phoenix, Tucson, and Flagstaff. These three metropolitan centers represent the southern, central, and northern regions of the state, and as the results to the survey revealed there are demographic, economic, and health-related differences among the three populations. Access to care also varies among the three regions. In this respect, the results of the survey have improved available data.

Healthcare Group made a number of assumptions in its product development and vision. For one, the working uninsured were not homogenous. Market research showed that the working uninsured vary across economic and demographic lines, and their requirements for health care services. In response, Healthcare Group developed a number of plan options aimed at different types of consumers: For example, one plan was designed to be comprehensive for consumers with chronic conditions and existing disease that required on-going medical care. Another was a preventive plan, designed for consumers in relatively good health who only required annual preventive care and limited access to more acute services (such as hospitalization). Another was designed for a lower income consumer that offered more affordable premiums.

The results of this survey validated that characteristics and needs of the working uninsured are not homogenous and that one product will not be sufficient to address the entire population. The survey results validated Healthcare Group's previous assumptions, but also offered valuable insight into potential new products to meet unmet need. For instance, from the questions related to benefits and pricing, it is evident that a limited benefit plan that covers only certain medical services (such as emergency room, preventive care, and doctor visits) would be attractive to some consumers, and could be priced within the price constraints indicated by respondents.

The data collected will be publicly available, and it is hoped that commercial carriers will take advantage of this market insight to create products that will address the needs of the working uninsured. Recent changes in legislation have enabled Arizona insurers to offer limited benefit plans without state mandated services. Healthcare Group hopes new, more affordable coverage options offered by commercial carriers will help reduce the number of uninsured in the state. Any future policy discussion around establishing a state high-risk pool could also benefit from these results.

Other Qualitative Findings on the Uninsured

Factors Contributing to the Lack of Health Care Coverage

RHO and Mercer's analysis of Arizona's health care marketplace identified a number of key factors contributing to the rate of uninsured. These included:

- Lower-income workers, especially those who work part-time, cannot afford health insurance premiums.
- Lack of adequate income to continue coverage under employment-based health plans after involuntary layoffs (i.e., COBRA).
- Smaller firms are less likely to offer insurance.
- Populations eligible for public programs do not know that they are eligible and do not know how to become eligible.
- Changes in immigration laws have made it more difficult for public advocates to find and enroll eligible populations in AHCCCS due to factors such as fear of deportation, cultural and language barriers.
- A belief that insurance is not necessary, e.g., the "Superman" effect resulting from the young healthy populations who see themselves as indestructible and feel health insurance coverage is not necessary.

Additionally, for residents in rural areas of the State who have an increased risk of uninsurance compared to their urban counterparts, the ability to access and receive adequate health care is made more difficult due to three (3) fundamental barriers:

- A critical lack of physicians and other providers.
- Geographic isolation.
- Hospital solvency.

The impact of these "rural barriers" is reflected in the fact that, of Arizona's 15 counties, three (3) entire counties are federal Medically Underserved Areas (MUA), a measure that includes both provider shortages and poorer health outcomes. Additionally a substantial portion of ten (10) other counties are designated as a MUA.

Affordability

In *Arizona Basic Health Benefit Plan: A Comprehensive Review*, Mercer noted that if the premium levels of the Basic Plan are set equal to the average cost of insurance available on the small-group market, a price generally available to the uninsured population already, then the plan will likely not be effective in meeting the financial needs of the uninsured. More reasonable comprehensive benefit designs will not be affordable to low-income uninsured without the use of significant subsidies by employers, state agencies or other sources. As illustrated through case studies presented in the paper, for someone at 200% of FPL, the typical premium and costs of deductibles and coinsurance can exceed 20% of the family's income. The issue of affordability

was also reinforced through the input AHCCCSA obtained from discussions with HCG members and other involved stakeholders.

Role of Safety-Net for the Uninsured

As in other states a core set of safety-net providers in Arizona deliver a significant level of health care and other related services to the uninsured. These safety-net providers include public and privately supported hospital systems (including emergency rooms), community health centers or clinics, local health departments, individual practitioners and other health care entities. These providers are supported through federal, state, local and private dollars. In Maricopa County it was estimated that: 1) 38% of individuals served in 2000 by primary care safety-net providers were uninsured and 2) 17% of the persons using the Maricopa emergency rooms in 2005 were uninsured. During 2001 to 2004, safety net providers in Maricopa County experienced significant increases in the number of patients and clinical visits. Due to limited resources, the safety-net providers clearly do not meet all the health care needs of these populations. In particular specialty care, including dental and behavioral health care has been cited as the missing piece of the safety-net puzzle.[16] During the period of the grant and grant extensions, Arizona saw the establishment of four Community Access Programs (CAPs), in Maricopa, Pima, Santa Cruz and Yuma counties. The CAP programs will offer an important option to those without other medical coverage.

Arizona has approximately 35 community health centers (14 of which are federally qualified health centers) with over 100 satellites. The patient mix for FQHCs consists of 35.3% uninsured, 37.6% Medicaid/SCHIP, and 7% Medicare.[17] When compared to the nation, Arizona has a low number of Bureau of Primary Health Care supported clinics per 100,000 population under 200% of FPL (3.2 vs. 5.2 nationally).[18] Also unlike other states, Arizona only has two publicly owned hospitals – settings that historically have provided significant amounts of the much-needed care to the uninsured. In addition to receiving federal support, the State allocates a limited amount of state generated tobacco tax monies to support safety-net providers. This amount has decreased in recent years due to increases in funds needed for Medicaid and decreasing tobacco tax revenues. The Arizona Hospital and Healthcare Association reported that gross charges for uncompensated care increased from $412 million in 2001 to $585 in 2004 (42% increase).[19] According to the State Health Access Data Assistance Center (SHADAC) State Health Access Profile, however, Arizona's uncompensated care spending per population under 200% of FPL was much lower than nationally ($136 per population under 200% of FPL vs. $245 nationally).

SECTION 2. EMPLOYER-BASED COVERAGE

This section provides an overview of how AHCCCSA approached the issue of studying the state of employer-based coverage in Arizona. A summary of the resulting baseline information gathered on employer-based coverage in Arizona is provided including the characteristics of Arizona's business environment and of those employers who opt to provide coverage.

APPROACH TO STUDYING EMPLOYER-BASED COVERAGE

Phase I: Development of General Plan For Coverage of Uninsured

Understanding employer-based coverage was included as a component of the analysis undertaken as part of the RHO study on health care coverage in Arizona. (See Section 1 of this report for a more in-depth discussion regarding the study approach). For this component of the their study the RHO drew upon data from Agency for Health Care Research and Quality, Center for Cost and Financing Studies, 1996-1999 Medical Expenditure Panel Survey (MEPS) – Insurance Component, Arizona Department of Economic Security, Research Administration and U.S. Census Bureau. The information gathered on employer-based coverage is contained in the three RHO documents - *Health Care Coverage in Arizona: An Overview, Health Care Coverage in Arizona: Data Book* and *Health Care Coverage in Arizona: Full Assessment*.[20] Additionally, AHCCCSA also gathered some qualitative information from previous small group employer surveys.

These documents were shared and discussed with both the Statewide Health Care Insurance Plan Task Force and Technical Advisory Committee. Through this study approach, the State was able to achieve its initial project goals by educating policymakers about employer-based coverage and its relationship with uninsurance in Arizona and facilitating the development of a General Plan for coverage of the uninsured in the State.

Phase II: Development of Specific Coverage Options

For purposes of developing the selected policy options, additional secondary data was sought and the baseline data was continually updated. However, as discussed under Section 1, the secondary data often did not provide the level of detail needed to make well informed policy decisions, especially as it related to understanding the characteristics of small size firms not offering insurance. To supplement the limited quantitative data, AHCCCSA gathered qualitative data through a series of different stakeholder interviews (rural self-insured employers, rural providers and HCG members and related stakeholder groups.

Phase III Focus on Small Business Coverage through Healthcare Group

As noted in Section 1, AHCCCSA focused its efforts in 2004-2006 on the working uninsured in small businesses. Information was gathered through a community consortium in Southern Arizona and through surveys, and focus groups specific to this sector of the population, with the intent of identifying barriers to small businesses in securing coverage and the types of coverage products that would meet their needs. In addition, information was gathered and planning efforts were undertaken to develop linkages to connect those without coverage to available coverage options.

DESCRIPTION OF EMPLOYER-BASED COVERAGE

Arizona's Business and Employment Environment

In 2005, the leading industries and occupations in Arizona were similar to the rest of the United States in that:[21]

- Education, health and social services; and retail trade were the two ranking industries in terms of employment at 19% and 12% respectively
- 79% of the people employed were private wage and salary workers, 15% were government workers and 6% were self-employed
- The three most common occupations were: management, professional and related occupations (33%); sales and office occupations (27%); and service occupations (17%)

Arizona's business environment differs from the rest of the U.S. in the greater role construction (11% vs. 7.7% in U.S.) and the arts, entertainment, and recreation, and accommodation, and food services (10% vs. 8% in U.S.) industries play over manufacturing (8% vs. 12% in the U.S.). This is not unexpected given Arizona's rapid growth with its continual demand for new housing and its draw as a tourist destination.

Of the 103,397 private-sector firms in Arizona 68.3% had fewer than 50 employees.[22] The smallest firms, those with fewer than 10 employees, comprised 50.0% of all firms in Arizona, while large firms, those with 1,000+ employees, comprised 19.6% of all firms. However, of the 1,956,808 employees, only 9.3% (i.e., 182,547) of all employees worked in firms with less than 10 employees while 46.3% worked in firms with 1,000+ employees.

Although Arizona's statewide unemployment rate continues to be below the national average (4.1% vs. 4.5% in December 2006), the State's median household income was only $44,282 (vs. U.S. average of $46,242) with 14.2% of Arizonans having incomes in the past 12 months below 100% of FPL (vs. 13.3% for the U.S.).[23] Arizona is ranked 23rd among the states in 2005 in average wage/salary per job ($37,830).[24]

General Description of Employer-Based Coverage in Arizona

The description of employer-based coverage in Arizona provided in this section has been updated from the original information compiled by RHO. Most of the information provided is from the 2004 Medical Expenditure Panel Survey – Insurance Component. Any significant changes in the data from that which was collected initially and/or reported in the March 2004 SPG Report to HHS are noted.

Overview

Historically a lower percentage of Arizonans have been covered by employment-based coverage than the rest of the U.S.[25] In 2005, 52.5% of Arizonans (vs. 59.5% for the U.S.) had employment-based coverage. The percentage of Arizonans covered through employers had steadily increased from a low in 1996 of 50.3% to a high in 2000 of 59.1%, but declined once again with the downturn in the economy. While the nation as a whole reflected a similar trend, the changes were not as marked as it was in Arizona.

The percentage of private-sector employers who offer health insurance has varied over the last ten years (see Table 2 below). In 2004, 56.1% of private-sector employers in Arizona offered health insurance as oppose to 55.1% nationally. While this is higher than the previous year (2003), it is lower than 2000 when 62.9% of private-sector employers offered health insurance to their employees.

Table 2. Arizona Private-Sector Employers Who Offered Health Insurance by Firm Size: 1996 - 2004

Year	Total	Less than 10 Employees	10 – 24 Employees	25 – 99 Employees	100 – 999 Employees	1,000 or More Employees
1996	55.1%	32.9%	72.6%	73.5%	78.9%	88.6%
1997	53.2%	31.3%	50.0%	87.7%	100%	99.2%
1998	53.7%	32.8%	59.6%	78.4%	96.3%	95.5%
1999	58.8%	35.7%	65.9%	83.9%	96.2%	99.4%
2000	62.9%	43.9%	64.3%	85.2%	91.9%	100.0%
2001	58.9%	37.6%	57.3%	81.5%	96.0%	100.0%
2002	52.4%	28.4%	60.9%	72.7%	94.4%	98.8%
2003	52.4%	29.2%	66.1%	80.3%	82.1%	98.7%
2004	56.1%	33.2%	53.2%	63.8%	90.3%	98.4%

Source: Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, Medical Expenditure Panel Survey – Insurance Component.

Firms Not Offering Coverage

Some of the key characteristics of firms that do not offer coverage, as compared to firms that do are provided below.

- Employer Size (including self-employed): As reflected in Table 2 above, firms not offering health insurance typically are smaller size firms.[26] In 2004, 61% of the firms in Arizona with less than 50 employees did not offer insurance as opposed to 7.2% of the firms with 50 or more employees. The percentage of small size firms in the U.S. not offering insurance was lower (58.1% for small firms and 4.0% for larger firms). Although data was not available on the number of persons who are self-employed in Arizona, in 2003 the estimated number of non-employers (typically self-employed individuals operating very small unincorporated businesses which may or may not be the owner's primary source of income), was 330,760; representing 14.2% of all employees.[27]

- Industry Sector: The 2004 MEPS data reported the following percent of private-sector establishments by industry groups not offering health insurance:

    - 61% for agriculture, fish, forestry and construction (representing 12.6% of all firms, 16.2% of employees)
    - 50.3% for retail/other services/unknown (representing 42.6% of all firms, 40.2% of employees)
    - 37.9% for mining and manufacturing (representing 3.9% of all firms, 7.6% of employees)
    - 35.5% for professional services (representing 22.7% of all firms, 18.5% of employees)
    - 29% for all other (representing 18.1% of all firms, 17.5% of employees)

- Employee Income Brackets: Firms with a higher percentage of low-wage employees (50% or more) were more likely not to offer insurance (61.2%) than those firms with fewer low-wage workers (34.7%). This same trend was seen when looking at percent of establishments that do not offer health insurance by wage quartiles:[28]

    - 58.2% in Quartile 1 (representing 39.6% of establishments in Arizona)
    - 43.0% in Quartile 2 (representing 27.3% of establishments in Arizona)
    - 32.6% in Quartile 3 (representing 15.6% of establishments in Arizona)
    - 23.2% in Quartile 4 (representing 17.6% of establishments in Arizona)

- Percentage of Part-Time and Seasonal Workers: The fewer full-time workers the firm had the less likely the firm was to offer health insurance. The percentage of firms not offering health insurance was:

    - 64.5% of firms with less than 50% full-time employees
    - 47.9% with 50% to 74% full-time employees
    - 37.1% with 75% or more full-time employees

- Geographic Location: Specific information on employer-based coverage by geographic area was not collected. However, a survey conducted in 2000 of small size employers found firms in metropolitan areas of Arizona were more likely than those in rural areas to offer health care coverage.[29]

- Others: The MEPS data also revealed some other distinct characteristics regarding establishments not offering health insurance, including:

    - Newer firms (less than 5 years) were more likely not to offer health insurance (77.3% vs. 44.9% for longer established firms in which the age of firm was 5 or more years).
    - For-profit, unincorporated firms were more likely not to offer health insurance (72.2%) than non-profit firms at 19.1% and incorporated for-profits at 38.2%.

Firms Offering Coverage

- Costs of Policies: From 1996 to 2004, the average total single premium (in dollars) per enrolled employee at private sector establishments that offered health insurance doubled. Nationally, the average premium increased from $1,991 in 1996 to $3,705 in 2004. In Arizona the average single premium increased from $1,791 to $3,438 falling slightly between 1998 and 1999. The average cost for a single premium in establishments with less than 10 employees was greater than that of firms with 1,000 or more employees ($3,775 vs. $3,437).

  During the same period 1996-2004, the average total family premium (in dollars) per enrolled employee at private sector establishments that offer health insurance also doubled both in Arizona as well as nationally. However, like the single premium, the 2004 average total family premium in Arizona, was consistently lower than the national average for all size firms (e.g., overall average was $8,979 vs. $10,006).

- Level of Contributions: In 2004, the percent of total premiums contributed by employees enrolled in single coverage at establishments that offered insurance was 19.2% (or $662) and for family coverage it was 25.1% (or $2,253). While the percent contribution has not changed much since 1999, the actual dollar amount paid by the employee has increased as a result of the increase in total premium costs. The average contribution for single coverage was less in small size firms with less than 50 employees than firms with 50 or more employees ($499 with employees contributing 14.3% to the total premiums vs. $703 with employees contributing 20.5%).

- Percentage of Employees Offered Coverage Who Participate: In 2004, 68.9% of employees (full and part-time) who worked for firms offering health insurance, were eligible for coverage. Of those employees eligible for health insurance 78.3% opted to enroll in health insurance at establishments that offered health insurance. The percentage of employees who were eligible for insurance has continued to decline from 1999 when it was at 80.7%. Eligibility and participation by part-time employees was much lower with

only 19.3% eligible for insurance coverage through their employee and 43.0% opting to enroll in the health insurance offered by these employers. Both the percentage of part-time employees eligible for coverage and the percentage opting to enroll had declined since 1999 when 24.8% were eligible and 67.6% opted to enroll.

Other Qualitative Findings on Employer-Based Coverage

Due to policymakers' strong interest in addressing lack of coverage among small size firms, AHCCCSA, during Phase I, gleaned additional qualitative information by reviewing the results from recently conducted surveys of small size firms. This information was enhanced during Phases II and III through stakeholder interviews, surveys and focus groups conducted by AHCCCSA in an effort to understand how Healthcare Group of Arizona (HCG) could become a viable solution for providing accessible and affordable insurance to the uninsured working in small size firms (see discussion under Section 4). The information obtained through these efforts was used in developing a new business plan for HCG to become a more effective program in reducing the number of uninsured and later on in the development of new benefit packages for the program.

Surveys of Small Size Employers

During Phase I of the project, AHCCCSA examined the results from three surveys conducted of small size employers in Arizona to understand their issues regarding purchasing of health insurance. In all the surveys affordability and accessibility of health insurance was raised as a key concern.[30] Additionally, for some small businesses the purchasing of health insurance for employees was not viewed as a key business priority. A brief overview of these surveys is provided below.

Small-Business Survey Arizona 2000: In 2000, a random telephone survey of 401 owners and managers of Arizona businesses having fewer than 50 employees was conducted by WestGroup Research for the Arizona Hospital and Healthcare Association, Arizona Chamber of Commerce, Blue Cross and Blue Shield of Arizona and the St. Luke's Charitable Health Trust.[31] The survey found that for small size businesses in Arizona, employee health was generally not seen as a primary business issue with key areas of concern being maintaining a quality workforce, meeting customer needs or governmental regulation.

Firms who offered health coverage recognized that it was important to employees and used it to attract and keep them. They would only discontinue coverage in the face of a major increase in the cost of premiums. Due to cost, half of these firms offered employee-only coverage. Of their employees who declined coverage (18.6%), it was generally because they had coverage through a spouse (41%) or they could not afford it (26%).

Firms that did not offer coverage did not see a strong link between offering a health care plan and attracting and keeping employees. It was seen as a major drain of finances; requiring a major commitment of resources. Many of these employers rejected the possibility without even investigating coverage options. These firms noted the following factors might increase the likelihood that they would offer employee health insurance:

- 25% tax credit in addition to the normal deduction (27%).
- Possibility of having a harder time getting and retaining employees (25%).
- Tax on firms that did not offer (21%).
- Competitors offered a plan (15%).
- Lower premiums (25%).

Arizona Department of Insurance: As part of a required evaluation of Arizona's Accountable Health Plan (AHP) laws, the Arizona Department of Insurance conducted an informal survey of groups representing the interests of small size business employers to find out the experiences of their members or clients in the small group health insurance market.[32] The survey responses indicated:

- Small size employers continue to experience limited access to group health insurance for reasons of both availability and affordability.
- Ongoing impediments to availability were related to administrative factors, compliance issues, product limitations and lack of competition.
- Small size employers uniformly describe affordability as the biggest access issue and perceive employee health status, prescription drugs, statutory mandates and lack of competition to be the primary affordability problems.

National Federation of Independent Business in Arizona: A survey conducted by the National Federation of Independent Business in Arizona found the cost of health care to be the top issue for small size businesses in Arizona. As a result of the survey the organization's 2002 legislative agenda recommended:

- No new state health mandates.
- Increase buying power of small-businesses by allowing them to pool together.
- Provide a health insurance income-tax credit (state and/or federal) for working uninsured.
- Create state medical savings accounts, tax-free accounts to help pay for the cost of health care that can roll over balances to future years.

2006 Healthcare Group Employer Focus Groups

In the original continuation grant proposal for 2004, HCG proposed funding a study by an outside consultant to quantify its impact on reducing the number of uninsured workers in Arizona. HCG membership steadily increased while the number of uninsured in the state has increased from 17.0 to 17.1 percent of the state's population (according to the Henry Kaiser Foundation). Other sources, such as the U.S. Census bureau, place the number as high as 20 percent. Since at best HCG has only stemmed the tide of this growth, it was felt that a more appropriate use of HRSA funds would be to study the success of HCG in attracting and retaining the uninsured businesses that do enroll in the program. To that end AHCCCSA received approval to reframe one of its objectives to better understand its success in attracting and retaining small employer groups.

Five focus groups were conducted in July and August 2006 with representatives of 33 small employer groups currently insured by HCG in three locations in the state (Phoenix, Tucson and Prescott) to:

- Determine how small employers heard about HCG (i.e., preferred communication mechanisms) and the messaging that attracted them;
- Identify the factors (i.e., perceptions and experiences) that attracted small employers to HCG and HCG products, motivated them to enroll, induced them to maintain coverage, and would cause them to terminate coverage; and
- Gauge interest in potential additional HCG products and services.

Key findings from this study include:

- Employers heard about HCG primarily through word-of-mouth from small business colleagues and a variety of outreach mechanisms used by HCG to increase public awareness;
- Key factors that attracted employers to HCG were low cost, guaranteed issue, and the ability to insure small groups and part-time employees;
- Employer groups were satisfied with HCG overall and said that they would not be able to offer healthcare coverage to their employees if HCG were not available. Premium increases were perceived as reasonable in relation to quality and scope of services. A large majority of employers said that quality was comparable to or higher than cost;
- Affordable cost, expanded provider networks, good coverage, and quality customer service are the top factors that would keep employer groups with HCG;
- Improvements in the reenrollment process (that HCG enacted after complaints that the process was difficult to understand and overly time consuming) were praised. Areas of dissatisfaction included problems with customer service responsiveness, confusion about billing, and the "AHCCCS [Medicaid] stigma," meaning a lack of differentiation between HCG and AHCCCS in the minds of providers and their office staff that have led to experiences of rudeness and disrespect;
- HCG is offering the appropriate number of benefit plan options for adequate employee choice. There is interest in a number of potential additional coverage options and insurance products such as life insurance and short-term disability protection;
- Small employers were unanimous that their ability to offer health insurance had a positive impact in their attracting and retaining quality employees.

It is interesting to note the similarities and differences among the findings from the 2006 focus groups compared to the *Arizona 2000* survey.

- In 2000, respondents most frequently mentioned finding good/qualified employees (34%) and government relations (11%) as their biggest business challenges. However, in 2006, 33% of respondents described their greatest business challenge as providing healthcare benefits for employees, an issue that was mentioned by only 4 percent of the 2000 participants.

- Cost increase was identified as the top reason that would cause a firm to drop insurance coverage for employees in both studies.

HCG Research on Southern Arizona Small Business Coverage - 2006

An independent research firm, Flanagan-Hyde Solutions, LLC, conducted six focus groups with small business owners or managers in southern Arizona in October 2006. Besides the two core counties of Pima and Santa Cruz, the Cochise County and Yuma County "Covering the Uninsured" Task Forces participated in the project and AHCCCS provided assistance in recruiting participants. Support was also provided by the Tucson Hispanic Chamber of Commerce, Arizona Small Business Association (Tucson), Sierra Vista Chamber of Commerce, City of Bisbee Council on Economic Development, and Copper Queen Community Hospital (Bisbee).

Research objectives were to better understand perceived barriers to providing health insurance coverage, wellness benefit preferences, and support for state and federal policies to increase coverage. Prior to the facilitated focus group discussions, respondents completed a written survey. In some cases, participants stated that the opinions they expressed on the survey shifted during the course of the discussions.

Key findings from the focus groups included:

- Many small businesses want to provide health insurance to employees but cannot afford the high cost of premiums.
- While small business owners strongly agree that a crisis exists, there is no consensus on the best approach to increasing health care coverage. Their proposed solutions included a variety of options ranging from greater reliance on private enterprise to increased government involvement and multiple- or single-payer universal coverage models.
- Emergency coverage, doctor visits, hospital stays, annual physicals and preventive care, prescription drugs, and affordable maternity and family coverage options are the top benefit priorities.
- Employee wellness programs are viewed as underutilized and a less important component of health insurance coverage. While small business employers are, in principle, supportive of employee wellness, they frequently see programs as an extra cost and believe employees should assume more personal responsibility and accountability for their health behaviors.
- To make coverage more affordable, support was expressed for group purchasing arrangements, tax credits to help offset the cost of health insurance premiums, state-based reinsurance arrangements, government-negotiated insurance premium caps, and eliminating the existing mandated "bare period" for health coverage eligibility.

SECTION 3. HEALTH CARE MARKETPLACE

This section provides an overview of how AHCCCSA approached studying the State's health care marketplace. Also included is a summary of the resulting baseline information that was gathered on the current health care market place in Arizona as well as other states' experiences with the implementation of coverage expansion strategies.

APPROACH TO STUDYING THE HEALTH CARE MARKETPLACE

Phase I: Development of General Plan for Coverage of Uninsured

In order to develop the general plan for coverage of the uninsured, considerable energy was expended on gaining an in-depth understanding of Arizona's health care marketplace, including examining the success of coverage expansion efforts in other states. To assist with this task, AHCCCSA contracted with Mercer, Inc and Milliman USA, Inc. Based on literature reviews; discussions with staff responsible for health coverage programs in selected states and staff consultants with experience working on various programs; and analysis of local state data files, a series of issue briefs were produced. The resulting issue briefs, in turn were distributed to members of the Statewide Health Care Insurance Plan Task Force and the Technical Advisory Committee and discussed at subsequent meetings of these groups.[33]

Phase II: Development of Specific Coverage Options

In order to develop specific coverage options, more detailed information was gathered by AHCCCSA as it related to health care marketplace in rural Arizona and the current small group insurance market.

As it pertains to the rural health care marketplace, AHCCCSA conducted two separate qualitative studies involving interviewing:

- Over 90 rural practitioners throughout the State about issues and strategies related to healthcare infrastructure and the development of an accessible and affordable statewide health care system; and
- A small group of rural public-sector employers and employee benefit managers about strategies employed to keep coverage affordable and barriers faced in providing health care to their employees.

Besides sharing these reports with the Statewide Health Care Insurance Plan Task Force and other interested stakeholder groups, the information in the reports was used by:

- AHCCCSA in the development of the 2003 RFP for acute care health plans.
- University of Arizona Medical School in the development of its plan to address physician shortages in the State.

- University of Arizona, Rural Health Office in the development of a plan to improve health care in rural areas of the State.

To develop benefit plans that are more marketable to small businesses, HCG researched existing benefit plans for small businesses, spoke to business and trade associations and local chambers of commerce to solicit input on the needs of the uninsured and perceived coverage barriers. Additionally, in response to interest expressed by the Statewide Health Care Insurance Plan Task Force, AHCCCSA had Mercer analyzed the cost for small group products using a "Medicaid" benefit package. This in turn was shared with the Task Force members.

Phase III: Focus on Small Business Coverage through Healthcare Group

One of the tasks in the 2004 HRSA continuation grant was to survey the working uninsured to determine their specific needs, perceptions and price sensitivity related to health insurance. Part of the preliminary research to develop that survey led to changes in the HCG benefit designs and new product development, which significantly improved the "attractiveness" of the HCG program for many small employers. In October 2004, HCG introduced deductible options to its HMO products that resulted in lower premiums, making HCG more affordable for smaller businesses. HCG had previously expanded its product line to include benefit plans designed for particular health needs and lifestyles: a plan called "Secure" was introduced for preventive and routine care, designed for members in relatively good health requiring mostly routine medical care; a plan called "Active" was introduced for active, younger, and lower-income members that covers preventive and routine care, in addition to more acute care at varying levels of co-payment. The addition of deductibles further lowered premiums for these products, which was welcomed by the small business community. Again, the preliminary studies related to the statewide survey helped fine-tune these benefit plans and make them more attractive to the sociodemographics of the working uninsured.

In September, 2005, HCG introduced a statewide PPO called Medallion Metals. Using the Arizona Foundation for Medical Care (AFMC) as its provider network, the new PPO offers access to one of the largest provider networks in the state, as well as a national wrap-around network for emergency and urgent care services. The three "Metal" PPO plans are called Medallion Platinum, Gold and Silver, and follow the same product philosophy as the Healthstyles HMO (Platinum being the comprehensive plan; Gold and Silver the preventive, lower cost alternatives). In addition, HCG introduced a consumer-driven high deductible health plan called Platinum Plus that meets the federal requirements for pairing with a health savings account (HSA). The PPO plans offer a broader range of benefits than the HMO plans, and include coverage for previously excluded services like mental health and substance abuse treatment. In March 2007 a statewide "point of service" (POS) product, and a limited benefit plan (called "Essentials") became available for prospective members earning under 300% FPL.

The HMO option remains the most popular. Offering more benefit options increased the interest in HCG, but it also resulted in more people with chronic conditions and existing disease buying down to less expensive plans while utilizing services at the same rate. As a result, HCG will closely monitor for increases in its medical loss ratio and be prepared to take steps to ensure financial stability.

In January 2006, HCG also began offering employer groups access to optional dental and vision benefits. Dental benefits are offered through Employers Dental Services, and Vision benefits through Avesis (the same vendors that administer dental and vision benefits for state employees). Response to these benefit options has exceeded expectations, with 7,790 members enrolled in the Dental option and 6,022 members enrolled in the Vision option as of June, 2006. Any eligible employee is able to elect Dental and Vision coverage for themselves and their dependents.

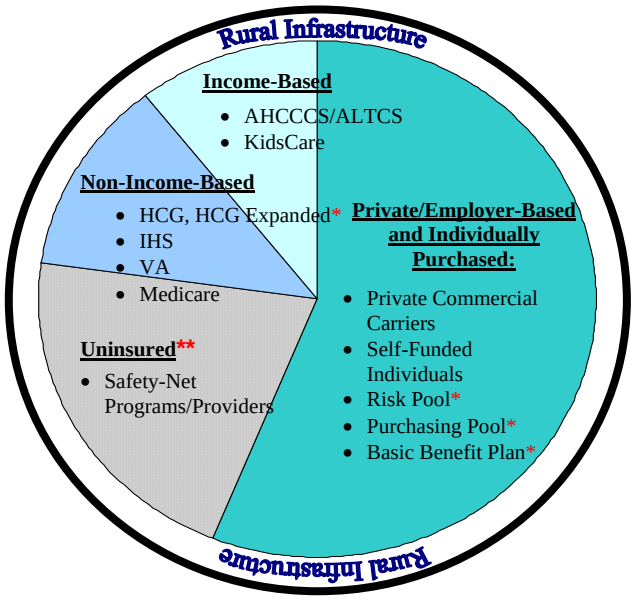
In February 1, 2006, HCG expanded pharmacy benefits for all Healthstyles (HMO) members. The previous two-tier benefit was expanded to three tiers with the addition of a non-preferred brand category to the formulary. This new third tier includes previously excluded medications such as psychotropics used to treat mental health conditions, depression and attention deficit disorders. To accommodate this expansion, HCG restructured pharmacy co-payments. Previously, pharmacy co-payments varied by benefit plan. Effective February 1, 2006, co-payments were standardized across all three benefit plans.

In July, 2006, HCG expanded the scope of its preventive benefit in both the HMO and PPO products to include screenings for colorectal cancer, diabetes and osteoporosis. Previously, HCG preventive benefits included only annual wellness exams (physicals), mammograms and Pap smears for women, PSA screening for men, and adult and childhood immunizations. Preventive services have age, sex, diagnosis and frequency limitations.

DESCRIPTION OF HEALTH CARE MARKETPLACE IN ARIZONA

A general overview of health care coverage in Arizona is set forth in the following diagram – "Health Coverage in Arizona" (Diagram 1 below). This diagrams was prepared by AHCCCSA for the Statewide Health Care Insurance Plan Task Force in order to illustrate the types of

Diagram 1: Health Care Coverage in Arizona



* = Proposed Programs being considered by the Task Force

** = Uninsured Characteristics:

- Rural Areas
- Small & Medium Employers
- Low-Income (not poor)
- Early Retirees
- Eligible, but not enrolled

coverage for those publicly-sponsored programs that AHCCCSA administers.[34]

As discussed in Section 2, the majority of Arizonans are covered through employer-based coverage. As of July 2006, 1,035,407 Arizonans (approximately 17%) were covered through public-funded income-based programs (i.e., Title XIX/XXI).[35] The Center for Medicare and Medicare (CMS) reported 796,862 Medicare beneficiaries in Arizona (approximately 13%) as of January 2006. In addition to publicly supported programs, the State of Arizona is one of the largest employers in the State, in 2005 the State employed 36,633 individuals with approximately 60,000 employees/retirees and their dependents enrolled in the State's health care benefit program.

In Arizona, the unique tribal health care delivery system plays a more prominent role than in the health care delivery systems found in other states (over 160,000 Native Americans living on-reservations). For Arizona's 21 tribes, Indian Health Services (IHS) is the primary provider of medical care, especially on-reservation. Through self-determination some tribal nations have assumed partial or full control of medical care for respective tribal members. Given limited IHS dollars and limited availability of some services (i.e., specialty care), many tribal members are forced to travel long distances to receive needed medical care.

Recent Health Care Marketplace Trends

One consistent way in which Arizona has been able to monitor changes that are occurring to its health care marketplace is through the Center for Studying Health System Change (HSC), Community Tracking Study. Phoenix is one of 12 communities that HSC track every two years through site visits. Despite its limited geographic focus, it does provide some valuable information regarding recent trends in the State's health care marketplace, many of which are applicable statewide. In the 2005 Community Tracking Study the following key developments were reported:[36]

- Rapid population growth continues to strain health care resources (e.g., long delays in emergency rooms, nursing shortage), despite significant hospital expansions
- Arizona's Medicaid and SCHIP program (AHCCCS) has continued to grow, covering over one million persons
- Although the county safety-net provider (Maricopa Integrated Health System) faces funding and cash-flow problems, the rest of Phoenix's safety-net remains strong with expansions of federally qualified health centers.
- Certain procedures and diagnostic services are being shifted away from general hospitals to physicians' offices and freestanding facilities.
- Efforts to develop a uniformed pay-for performance payment system for physicians are hindered by the abundance of health plans in market, the small size of physician offices and their lack of technology, and the limited leverage that health plans have with physicians due to health care professional shortages

Historically Arizona had a high HMO penetration rate, but like the rest of the nation, Arizona's health care market has seen a movement away from the traditional managed care approach. Arizona's current HMO penetration rate is approximately 18.3%.[37] (Kaiser reported that the

HMO penetration rate was 25.5% in July 2002.) Managed care still plays a dominant role in the public-sector service delivery system:

- All persons eligible for the State's Medicaid and SCHIP program (i.e., AHCCCS) receiving their acute health care services through one of eight capitated managed care health plans
- In 2005, Kaiser reported that 27% of Arizona's Medicare beneficiaries were enrolled in one of 13 Medicare Advantage plans (nationally 13% were enrolled in Medicare Advantage Plans)
- According to Kaiser approximately 6% of Arizona's Medicare beneficiaries were enrolled in a Medicare Special Needs Plan (SPN) in July 2006 (Arizona had the third highest number of SNP enrollees nationally; with only 1% being enrolled in SNPs nationally)

In the Department of Insurance's last evaluation of the Accountable Health Plan laws it found that in Arizona as in other states the small group market is shrinking.[38] The availability of group health insurance to small size employers has been adversely affected by the decease in the numbers of Accountable Health Plans (AHP). In 1999 there were 104 AHPs but as of December 31, 2001 there were 54 AHPs. Of these it was estimated that only 27 AHPs were active in the small group market. In 2004 the Department of Insurance reported that there were 22 health insurers providing small employer group coverage (2 to 50 employees) to 320,950 enrollees.[39]

The HealthCare Group, the state-sponsored health insurance program for businesses with 50 or fewer employees, including individuals who are self-employed, has more than doubled in size over the past few years; growing from 11,102 enrollees in March 2004 to 26,062 enrollees in March 2007**.** This growth is attributed to the addition of new coverage products and improved marketing efforts.

Self-insured firms are becoming more prevalent in Arizona. In 2004, 36.3% (21,055) of the private-sector establishments in Arizona that offered health insurance self-insured at least one plan with 59.7% of private sector enrollees being enrolled in self-insured plans at the private-sector establishments offering health insurance.[40] This percentage has increased since 2002 when 17,944 (33.8%) of the private-sector establishments self-insured at least one plan. Seen as a strategy for controlling costs and making insurance "more affordable", the following issue briefs were produced by Mercer and reviewed by the Task Force to provide a better understanding of the self-insurance model:

- *Review of Self-Insuring of Health Benefits* explains the features and differences between fully insured funding arrangements and self-insured funding, as well as minimum premium funding which is a combination of fully and self-insured.

    - Self-insurance allows employers to eliminate insurance profit and risk charges and take control of plan design with the flexibility staying with the employer. The disadvantage is that assets may be exposed to legal liability due to self-funding and monthly cash flow can fluctuate.

- Successes of self-funded plans are linked to constant monitoring and assessment of costs and utilization, willingness to make changes when needed, selection of" best of breed" providers, targeted contracting with networks/providers for deep discounts, strong utilization and case management programs in place.

- *State Employee Health Plan Self-Funding Survey* looked at the approach taken by 34 state employee health benefit programs that are self-fund and found:

  - Sixty-eight percent of the states, self-fund at least one of their medical plans for state employees and five (5) more are considering self-funding.
  - Sixty-two percent fully-insure their HMOs while self-funding indemnity, PPO and other types of plans.
  - None include self-funded employee plans as part of a larger statewide health insurance reform or expansion initiatives.
  - Seventy-four percent allow other groups to participate, e.g., counties, cities, towns, political subdivisions, school districts.
  - All states contract with outside vendors to provide some type of administrative services.

The restructuring of current state employee coverage programs through adoption of a self-insured model was included as one of the recommendations in the General Plan developed by the Task Force. Since then both the State and the City of Phoenix have moved to self-insured health plan model for their employees.

Understanding Cost Drivers and Participation Factors

One of the Task Force's main goals was to see an increase in the availability of "affordable" insurance products in Arizona. As part of Phase I of the project, a number of policy briefs were completed that examined factors perceived by Task Force members as cost drivers as well as determinants of participation in health insurance programs. A brief description of these papers is provided below:

- *Health Insurance Administrative Costs* (Mercer) discussed factors impacting administrative expenditures and provided percentages of total expenditures spent on administration by insurance plan types in 2000.

  - Typical administrative functions include claims processing, network development and maintenance, case management, actuarial services, medical management, data collection and analysis, marketing and administrative management.
  - The level of administrative expenditures is dependent on breadth of services offered, special needs of the population, size of the plan, regulatory requirements, and efficiency in administering the plan.
  - While administrative expenditures have continued to increase in recent years, they have decreased as a percent of total expenditures. For insurance plan types in 2000, the percentage of total expenditures spent on administration was 12 to 18%

for indemnity or PPO, 12 to 20% for POS, 14 to 18% for commercial HMO and 10 to 21% for Medicaid HMO.

- *Financial Impact of Recently Enacted Health Insurance Mandates* (Mercer) conducted an independent cost study in order to estimate the financial impact of health insurance mandates recently enacted by the 1999 HMO reform law e.g., direct access to chiropractic services, standing referral requirement and access to medical supplies.

    - The study considered mandates in six (6) areas: administration, access to medical supplies, pharmacy, direct access to care, emergency services and clinical trials. Taken together, the estimated impact of the enacted mandates was a 5.7% increase in health care premiums.
    - Direct access to chiropractic services had the greatest cost impact at 3%.

- *Elasticity of the Demand for Health Care Services* (Mercer) discussed the relationship between the demands for health care as it relates to the cost of care, (i.e., relationship between increases in health care cost and the impact it has on the purchasing of health care and/or insurance).

    - Demand for health care is considered to be inelastic – changes in price tend to have a small impact on changes in quantity.
    - Similar to health care, overall health insurance is relatively inelastic (e.g. for every 1% increase in health care premiums there is an estimated 0.1% decrease of insured Americans).
    - The Urban Institute found that for every 1% increase in premiums as a percentage of income, there is a corresponding drop in presentation of approximately 10 %.

- *Arizona Basic Health Benefit Plan: A Comprehensive Review* (Mercer) examined the Arizona Basic Health Benefit Plan and the proposed basic plan being informally discussed among the Task Force members in the context of other states' approaches and critiques the plan in terms of benefit design variables as well as its overall affordability. The report found that the Arizona Basic Health Benefits are:

    - Not basic.
    - Not targeted at the uninsured.
    - Not affordable.
    - Not attractive since consumers are currently not showing much interest in purchasing the product.

Health Care Infrastructure

As reported in the Community Tracking Report, Arizona's unabated population growth is placing significant pressure on the current health care infrastructure and all its health care facilities, making it more difficult for the State to accommodate the needs of its growing population. The State is facing shortages of both professional staff as well as hospital beds.[41]

For example, in 2005 there were 219 physicians per 100,000 residents vs. a national average of 293, and 681 nurses to 100,000 residents vs. a national average of 782. In 2003 there were 1.9 staffed hospital beds per 1,000 population in Arizona vs. a national average of 2.8. The 2003 workforce shortage survey conducted by the Arizona Hospital and Healthcare Association found:[42]

- The vacancy rates for in-demand healthcare professionals (nurses, pharmacists, radiological technologists, medical technologists, respiratory therapists) had not improved substantially since the 2001 survey.
- Employee-focused programs had been effective in reducing turnover of health care professionals (e.g., turnover rate for nurses decreased from 27% in 2001 to 15% in 2003).
- The following conditions were identified as symptoms of insufficient hospital workforce: emergency room overcrowding and diversion, reduced staffed beds, dependence on contract labor, physician dissatisfaction; closed beds, reduced outpatient capacity, delayed surgeries and increased waiting times for surgery.

There are a number of efforts currently under way in the State to try and remedy some of these shortages, e.g., increase in training/educational slots for health care professionals, building of new hospitals especially in rapidly growing urban centers, increased investment in the State's telemedicine network, especially in rural areas. In May 2006, the Governor established an Emergency Medical Services Access Task Force, which issued a report at the end of the year identifying barriers and recommendations related to the shortage of physicians and other medical personnel who provide emergency and trauma level care. Efforts are under way to increase graduate medical education funding, and the Governor has proposed establishing an office to assist new and relocating physicians in setting up their practices in Arizona.

Task Force members were particularly concerned about the impact these workforce shortages were having on the already fragile rural health care infrastructure and the affordability and accessibility of coverage options for rural residents – a group considered to be at increased risk for uninsurance compared to urban residents. In order to better understand both issues hindering the development of a strong rural health care infrastructure and potential strategies to consider in improving the rural healthcare marketplace, AHCCCSA reviewed the findings from the following reports with the Task Force:

- *Initiatives to Improve Access to Rural Health Care Services* (Mercer) provided an overview of strategies that had been implemented by other states to increase access to health care in rural areas both in terms of increasing coverage and enhancing provider networks.

    - Key barriers identified include: lack of physicians and other providers, geographic isolation and hospital solvency issues (i.e., insufficient volume to justify size and capabilities).
    - Strategies employed by other states to address rural infrastructure concerns and provisions including: financial and technical assistance to make rural areas more attractive to practitioners, examples of collaboration between health and non-

health resources and/or urban and rural resources, changes in reimbursement methodologies for hospitals, and creative use of hospital space and resources.

- *Inventory of Arizona Strategies to Address Rural Health Care Infrastructure* provided a comprehensive description of specific strategies/programs that have been implemented in Arizona. These strategies were grouped according to those which:

    - Increase the number of rural practitioners.
    - Minimize geographic isolation.
    - Improve the viability of health care facilities.
    - Financially support rural-based health care service programs.

As a result of the information gained through both these reports and the information on the uninsured, the Task Force included the need to continue to develop rural health care infrastructure as one of their recommendations for addressing coverage issues in Arizona. The recommendation also included specific steps that should be taken by the State, e.g., increasing accessibility to medical services through student residency rotations and use of telemedicine networks. In an effort to support the further development of this recommendation, AHCCCSA as discussed earlier in this section, conducted two separate studies during Phase II of the project. This resulted in the following two reports

- *Rural Health Care Provider Interviews: Developing a Strong Rural Health Care Infrastructure Challenges and Successes* provided a plethora of information in the delivery of rural health care regarding issues and barriers, effective coverage strategies and needed changes and solutions.

    - Overall lack of providers in the communities including PCPs, specialists and other support practitioners.
    - Successful strategies to address recruitment and retention issues, included loan repayment, J-1 visa waiver program, income guarantee/financial assistance program, compensation and bonuses, scholarship program, and use of visiting physicians.
    - Successful strategies to support and extend productivity of rural providers included use of physician extenders, improved work environment, use of hospitalists, and specialty clinics using visiting physicians. Use of telemedicine and mobile diagnostic equipment received mixed reviews in terms of effectiveness.
    - Actions steps consistently recommended included controlling increasing malpractice rates through tort reform, providing incentives for physicians to practice in rural environments and continuing to allocate Tobacco Tax monies for primary care services.

- *Key Stakeholder Interviews of Rural Employers and Employee Benefit Specialists* examined strategies used by public-sector employers to ensure coverage is accessible

and affordable and identifies barriers purchasers faced in providing health care to their employees.

- All interviewed employers, representing major purchasers of health care in rural areas were partially self-insured and felt it had allowed them to hold down their health care costs.
- Most had made recent modifications in benefit structure to address increasing health care costs, e.g. increase deductibles, copays, institute drug formulary, etc.
- Lack of provider competition and availability of specialists were a key problem in being able to offer coverage.
- High premium cost was the main reason cited for employers in their community not offering coverage to employees.
- Examples of strategies to consider included increasing provider reimbursement rates, implementing incentives for providers to practice in rural areas, and increasing size of purchasing pools.

OTHER STATES' EXPERIENCES WITH COVERAGE EXPANSION

Other states' and other countries' experiences with health care delivery and coverage expansion played an important role in the policy deliberation regarding health care coverage in Arizona. In order to educate policymakers regarding experiences outside of Arizona, a series of policy issue briefs were prepared by Milliman USA, Inc. and Mercer, Inc. A summary of the findings from these papers is provided below:

- *Purchasing Pools* (Milliman) focused on purchasing pools established for small-employee groups and individuals/families and their effectiveness in improving access and affordability to health insurance.

    - Historically, challenges faced by pools have involved: low employer enrollment, lack of health plan participation, unwillingness of agents to promote, adverse selection, and the inability to offer PPO and POS plans.
    - Need to substantially increase the enrollment in pools in order to be viable and be able to offer lower prices.
    - Not able to lower prices enough to encourage more small-employers to offer insurance without significant subsidies or mandates.

- *High-Risk Pools* (Milliman) examined the types of risk pools implemented by other states to cover residents whose medical costs preclude them from obtaining coverage at affordable prices in the private market.

    - Risk pools play a major role in making coverage available to uninsurable individuals, reducing the number of uninsured and providing stability to the health care market.

- A key issue in establishing a high-risk pool is to make sure that it is well-funded including revenue sources besides premiums and assessments.

Although legislation has been introduced over the years to study or establish a high risk pool in Arizona, to date no statute has been enacted.

- *Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage* (Milliman) provided an overview of incentives that have been implemented by other states to increase private health insurance coverage as well as provided commentary on the effectiveness of legislative mandates at the state level.

    - SCHIP and premium sharing programs have been successful in enrolling targeted populations, although crowd-out may be a concern.
    - Tax credits and deductions are questionable for the uninsured and may be more appropriate to discuss at federal levels.
    - Small group market reform has led to stability, more readily available products and more predictable cost increases, but has not addressed the affordability issue and has had little or no impact on the number of uninsured.
    - Individual market reform has not been successful in reducing the number of uninsured.
    - Programs which are successful in reducing the number of uninsured generally involve some expenditure of public funds.

- *International Approaches to a Socialized Insurance System* (Milliman) provided a brief overview of the socialized medicine approach to the delivery of health care that has been operating in European and other select countries.

    - These systems are largely reliant on taxation, highly regulated, place a significant emphasis on preventive care, require co-pays and ration care through waiting lists.
    - To implement this type of system in U.S./Arizona, one would need significant increases in taxes to cover the uninsured, mandatory employer-based coverage, ERISA exemption, more uniformity of benefits, more regulation of provider fees, restrictions on patient choice of provider and income-based differentiation of benefits and/or contributions.

SECTION 4. OPTIONS AND PROGRESS IN EXPANDING COVERAGE

This section discusses the policy options selected by the State for inclusion in the State's general plan for coverage of the uninsured and steps that have been taken to actualize these selected options. In addition, more detail information is provided about two specific options whose further development became the focus of SPG grant activities (i.e., Healthcare Group and Premium Assistance Programs/Employer-Sponsored Insurance).

Options Selected for Inclusion in General Plan for Coverage of Uninsured

The Statewide Health Care Insurance Plan Task Force was responsible for developing a General Plan for coverage of the uninsured, a plan that would ensure health insurance was accessible and affordable for all Arizonans. Three factors were instrumental in guiding the Task Force as it selected options for inclusion in the General Plan:

- A set of basic principles for health care coverage in Arizona. Through a facilitated discussion, the Task Force members developed four basic guiding principles:

  - Health care, especially basic benefits should be available and accessible.
  - Health care should be affordable and properly financed.
  - Health care should be provided through a seamless system, offering the highest quality care.
  - Health care should be done in collaboration and in cooperation with the various stakeholders, both public and private sector and it should foster competition.

  Each of these guiding principles was accompanied by a set of specific questions (criteria) that were revisited throughout the course of the Task Force's deliberations surrounding development of a plan to address accessible, affordable health care in Arizona.

- Policy issue briefs on coverage strategies and data on the uninsured and health care coverage in Arizona (see discussion in Sections 1 – 3). In addition to better understanding Arizona's specific coverage related issues, Task Force members gained insight into the effectiveness or lack of effectiveness various strategies have had on addressing the issue of accessible and affordable health insurance.[43]

- A state budget crisis. With a $1.2 billion shortfall for FY2003, Task Force members felt any options to expand coverage which required state funds would not be feasible at this time, although should be given consideration over the long-term. The Task Force members were also concerned about maintaining recent AHCCCS coverage expansions.

As part of its final report to the Legislature and Governor, the Task Force set forth a General Plan for providing Arizonans with accessible and affordable health insurance. This included further exploration of four broad strategies:

1. Narrow the gap between existing public and private health coverage programs through examining the feasibility of implementing:

    - Insurance reform to promote more accessible and affordable coverage options, especially those targeted at the individual and small group markets (e.g., Healthcare Group).
    - Consumer and employer education initiatives on the value of health care coverage and existing options within the private marketplace.
    - Private-public coverage programs such as a high-risk pool, full cost buy-in program or a premium assistance employee buy-in program.
    - Program for cooperative purchase of employee health care benefits by small group employers.

2. Restructure current state employee and retiree health care benefit programs (e.g., self-insurance system and expansion of pool size).

3. Enhance existing public-supported programs through:

    - Support of effective outreach programs.
    - Coverage of parents of Title XXI children expansion of coverage groups.
    - Development of a plan to expand Title XIX coverage groups through state plan amendments.

4. Improve the rural health care infrastructure through:

    - Continuing to support safety-net providers.
    - Fostering volunteerism and engaging the services of retirees from the health care professions.
    - Encouraging competition between health care service providers.
    - Increasing accessibility to medical services.
    - Developing a plan to more effectively coordinate current rural health care resources and programs.

In order to ensure further development of these options, the Task Force also recommended the Task Force be continued in statute (scheduled to expire in December 2001), changing the name of the Task Force to the Statewide Health Care System Task Force and adding three additional members (i.e., representatives from House of Representatives, Senate and University of Arizona Health Science Center).

Legislation (Laws 2002, Chapter 265) was passed in the spring of 2002 that codified the Task Force recommendations and continued the efforts of the Task Force until December 2004.

PROGRESS ON SELECTED OPTIONS

The State has continued to make progress on further refining and/or implementing strategies that support the coverage options set forth in the General Plan adopted by the initial Task Force. In addition, to lend further support to this effort, AHCCCS has included in its 2006 – 2011 strategic plan a specific goal to "reduce the rate of uninsured Arizonans by providing affordable health care coverage." Information is provided below for two of the options - HCG Enhancements and Design of a Premium Assistance Program.

Healthcare Group Enhancements

Healthcare Group (HCG) has and continues to be an integral part of the SPG efforts. It is viewed as an important strategy for making coverage accessible and affordable to small businesses, especially for individuals who are self-employed. The challenge in both Phase I and Phase II of this project was to develop strategies to allow the HCG program to become financially solvent and at the same time be able to offer affordable coverage to its target population.

Implemented in 1988, HCG was created to provide affordable and accessible health care coverage to small businesses with 50 or fewer employees and political subdivisions within the State. The program is administered by AHCCCSA and not subject to State insurance regulations for commercial plans. HCG's enrollment peaked in 1997 with slightly over 20,000 members. Enrollment then began to decline when the general health care market started to experience problems because of steep cost increases. In order to keep the program solvent, the Legislature began to subsidize the program (initially $8 million in 2000, decreasing to $4 million 2004).

During Phase I of the project, the ongoing viability of HCG became one of the Task Force's major concerns. Mercer conducted an analysis of HCG and presented the following findings to the Task Force:[44]

- Over a three-year period its medical costs rose 17% while premiums increased only 9%.
- The enrolled population showed features of a high-risk pool, with increasing acuity.
- HCG health plans experienced financial losses for the past three years.
- Administrative costs were above average for all HCG health plans due to low membership.

In addition to the General Plan, the Task Force recommended (and supported necessary legislation in 2002) to make the following recommended changes set forth in the Mercer report.

- Transferring administrative functions (marketing, enrollment and premium pricing) back to HCG (the State).
- Implementing a single uniform benefit package.
- Gathering household income information making it possible for the State to provide subsidies to only those in need.
- Establishing risk-adjusted premiums adequate to cover medical and administrative costs.

Although the modifications made as a result of the 2002 legislation were implemented, AHCCCSA realized the goal to make HCG into a viable insurance option for the uninsured could not be achieved through these modifications. If HCG was to significantly impact the uninsured rate in Arizona, additional research and planning were necessary to develop affordable products that would be appealing to small size businesses and low-income employees.

In February 2004, AHCCCSA developed and finalized a business plan with the overall goal to significantly increase HCG membership. In particular, low-income uninsured who do not qualify for AHCCCSA would be targeted through the development of additional customized benefit packages (e.g., PPO, deductible options, and FQHC plans). In developing this plan, AHCCCSA conducted extensive analysis of the current HCG program and healthcare insurance marketplace. Meetings were held with community interest groups (e.g., Hispanic, Asian, and Afro-American business groups, local chambers of commerce, credit unions) to solicit their input on new benefit packages and issues of affordability. Additionally, input about benefit design was solicited from interested persons visiting the HCG display booth at conferences and health fairs. Examples of input received included:

- Lower rates for family coverage and/or for those who do not use the system.
- Inclusion of a rate for an employee plus children.
- Offering a benefit plan that has deductibles.
- Inclusion of behavioral health drugs and care, vision and/or dental in a benefit plan.
- Only requiring businesses to pay premiums one month in advance as opposed to the current requirement for a two-month payment.
- Changing definition of full time employee from 20 hours or more to 32-40 so that it would be easier for businesses to meet participation requirements.
- Reduction in the amount of paperwork required to apply for HCG.

These discussions allowed AHCCCSA to further refine proposed product design and better understand issues of affordability for small businesses.

Support for the new HCG business plan became critical; especially since legislation was needed in order to actualize several of the strategies set forth in the business plan. Gaining this support proved to be a challenge. Several large commercial insurers viewed this new approach as potentially encroaching on their market share. AHCCCSA made numerous presentations to key stakeholder groups (e.g., Task Force, legislative budget committee, and commercial insurance companies). These efforts were greatly enhanced by having the support of both the Governor and Task Force members who saw further development of this program as one of the key strategies to be employed to reduce the number of uninsured in Arizona. After much negotiation, legislation was finally passed in May that included the following:

- Allows HCG to contract directly with providers in the event no contracted health plan is willing to provide an adequate provider network.
- Allows HCG to contract with commercial insurers.
- Allows HIFA parents of Medicaid/SCHIP children who participate in the Premium Assistance Program (see next section) to enroll in HCG.

- Allows uninsured persons who lost their jobs due to foreign trade and qualify for federal tax credit for health insurance to enroll in HCG (coverage option permitted under Trade Act of 2002).
- Allows HCG to pay insurance brokers/producers a one-time enrollment commission.
- Requires small business to go bare for 180 days to be eligible to enroll in HCG.
- Prohibits HCG and its plans from using the AHCCCS fee-for service rates for hospitals as a default rate.[45]

In order to further support the State's commitment to use HCG as a key strategy for reducing the number of uninsured, AHCCCSA utilized two HRSA State Planning Continuation Grants (2004 and 2005), enabling the state to:

- Conduct surveys and focus groups to gain a more thorough and detailed understanding of the characteristics and needs of the working uninsured in Arizona.
- Prepare a policy brief on the utilization patterns and service demands of the newly insured as gleaned from other national data and studies.
- Identify barriers at the community level that are preventing people from accessing coverage,
- Design linkages among state coverage programs, the business community, private health insurers, health care providers and the public to build a strong community partnership to maximize sharing of information that will increase access to healthcare coverage.
- Plan for technology changes to expand the scope of the Health-e-Arizona web-based screening and application process

The information gathered through these efforts was designed to allow AHCCCS to better develop strategies to both ensure HCG's self-sufficiency and to expand and improve HCG's ability to offer affordable health insurance options to Arizona's working uninsured. During the past three years, HCG increased its internal sales staff and implemented a broker compensation program that paid brokers a one-time enrollment fee for the eligible groups they enrolled. Increased outreach also played a key role in getting the HCG message to small business throughout the state. Being a state program, HCG does not have a large marketing budget and must rely on outreach and word of mouth as its primary source of new business. Legislative authority to pay brokers an enrollment fee, enacted in August 2004, helped increase HCG penetration into the small business market.

In addition, HCG surveyed the working uninsured to determine their specific needs, perceptions and price sensitivity related to health insurance. Part of the preliminary research to develop that survey led to changes in the HCG benefit designs and new product development, which significantly improved the "attractiveness" of the HCG program for many small employers.

The result of these efforts has been a significant increase in HCG enrollment since 2004. In March 2004 there were 11,102 individuals enrolled in HCG. In March 2007 that number grew to 26,062, an increase of 14,960 people. This represents a 135% growth in enrollment. Additionally, a total of 19,459 members have enrolled in the optional Dental and Vision plan. For all products combined, HCG enrollment was 45,521. Many factors have contributed to this

stellar growth, among them the introduction of new products and deductible options, the addition of a new health plan (Care1st), more aggressive and targeted outreach and marketing, expansion of the HCG sales force, legislative authority to pay one-time enrollment fees to brokers (SB1166), addition of dental and vision options, and finally the introduction of a statewide PPO.

The 2005 Continuation grant focused on efforts to increase enrollment of the uninsured in two counties, Pima and Santa Cruz, in southern Arizona. Efforts were marked by a strong collaboration of local partners led by the Pima Community Access program (PCAP). Key accomplishments are described below.

"Bridge" to stakeholders

After assignment of key grant staff, a "bridge team" was chartered and tasked with knowledge management across the HRSA SPG and a separate AHCCCS grant from the Robert Wood Johnson State Coverage Initiatives. Mutual updates, deliverables sharing, and a complementary design strategy have and continue to create significant synergy towards reducing the number of uninsured persons in the southern Arizona counties of Pima, Santa Cruz Yuma and Cochise. Using information supplied through this SPG, a core stakeholder group known as the Southern Arizona Uninsured Coalition (SAUC) worked with AHCCCS and HCG to generate community support and identify potential electronic enhancements that could help connect people to health coverage. Over the past 6 months, the group has evolved into the Southern Arizona Health Information Exchange (SAHIE).

SPG Uninsured Literature Review and Summary

A comprehensive library related to Arizona's uninsured in relationship to employer based coverage was created following an extensive literature review. It was organized by category and spanned 2001 to current. The resource materials were cataloged as: 1) Policy Papers and Consulting Reports 2) Studies and Reports 3) Slides, Stats and Presentations 4) Legislative Minutes (Uninsured Task Force) 5) Technical Advisory Minutes (Uninsured Task Force) 6) Newspaper Articles 7) Focus Group Reports 8) Links to other resources. New data sources and partners were identified, including Salt River Project, which funds an extensive review of Hispanic small businesses (in partnership with Arizona State University). Other local sources referenced in the literature review included Healthcare Group (2004 and 2006 focus groups), Pima County data, Governor's reports and Arizona Small Business Task Force resources. The review and companion summary is a living document, updated at least monthly, as new studies become available. Information and related resources outlined in the review have been used for the preparation of SPG and other reports, as well as for the facilitation guide for the SPG-HCG employer focus groups.

Comprehensive Inventory Grid of Coverage Sources

An exhaustive inventory of insurance and discount program options available in Pima and Santa Cruz counties was completed. The compendium includes all known products in the project market including: government, sliding scale, charity care, non-traditional products (discounted programs), commercial insurance products and Healthcare Group. The grid is currently being

used by the Southern Arizona coverage programs, and will be used to assist in continued design of Health E Arizona (see below). The grid is also being used to identify barriers to coverage and coverage gaps with community partners and to study high risk gaps. It is taking on new life as its information is being incorporated into the state connection/clearinghouse for heath and human services (see www.AZ211.gov)

Expand Health-e-Arizona (HeA) Application

Health-e-Arizona (HeA) is a web-based system to electronically screen and enroll persons in a range of publicly funded health programs using a single application. Currently, HEA screens each applicant for eligibility for most Arizona Medicaid programs and KidsCare (as well as Food Stamp and TANF eligibility). If the applicant does not screen eligible for a State program, the system may also screen for eligibility for the following discounted health care programs: Health Care Connect (Maricopa County); Pima Community Access Program (PCAP); and Santa Cruz Health Connection, depending on where the applicant lives and displays the family's income as a percentage of the Federal Poverty Level (FPL) to enable clinics to determine the sliding fee scale rate for the family as well as Food Stamp and TANF eligibility.

HCG and the HeA design team explored through 3 formal meetings and one formal Joint Accelerated Design (JAD) session how the tool could be used more effectively to link the working uninsured with HCG specifically, or, in the future with other insurers. Planning was completed to identify the programming changes needed to enable applications for assistance completed in HeA to result in electronic interface and/or reports that identify applicants who are self-employed or employed by small businesses who may then receive information about HCG. With the applicants' permission, this information will be used to support outreach and marketing of available insurance products and services. A series of mock-ups, or screenshots, and descriptions were developed to illustrate how the existing HeA functionality and data capture can be utilized to gather the data needed in a referral to HCG, as well as identify applicants for whom a referral to HCG may be appropriate.

This is a valuable tool for which AHCCCSA and HCG will continue to seek funding sources from public and private sites in order to implement necessary computer programming changes. The attributes of the system include:

- Preliminary eligibility results are available immediately to the applicant and the organization using Health-e-Arizona
- Enables community health clinics to screen and assist applicants who do not meet State eligibility requirements by offering services on a sliding fee scale
- Provides a timely and accurate process for community organizations to forward applications and verification information to AHCCCS and DES electronically
- Prints application documents for the applicant in English or Spanish
- Improves completeness of applications and helps community organizations identify the verification documentation required for eligibility processing
- Relieves state staff from processing applications for individuals who do not screen potentially eligible and enables applicants to access other community health care resources

- Helps reduce the number of uninsured Arizonans, by identifying those who could qualify for federal programs if they applied and providing a mechanism to apply on-line
- Improves communication between the public and private sectors to eliminate duplication of effort
- Provides on-line storage of applications and verification documents
- Provides an application management system for community organizations to track the status of the applications they create
- Provides community organizations with the final eligibility results from AHCCCS and DES
- One-stop shopping for applicants that does not require them to complete a confusing and cumbersome paper application
- Customers can apply in an environment where they feel comfortable

In addition, through a grant from the Robert Wood Johnson Foundation, efforts are underway in two other counties, Yuma and Cochise to conduct intensive community based and state supported efforts to identify and communicate with individuals and employers who currently are not insured. Partners in these efforts include coalitions of community health centers, Community Access Programs, county governments, hospitals, medical providers, and business leaders. Where possible and appropriate, information and lessons learned from each grant are shared to enhance coverage success.

Premium Assistance Program (or Employer-Sponsored Insurance)

"Development of private-public coverage programs such as premium assistance programs" was one of the selected coverage options in the original Task Force plan. Given the looming state budget crisis at that time, this type of approach was of particular interest to legislators as it was seen as a way to support coverage expansion without requiring additional state funds and as support for public-private partnerships for employer-based insurance. Additionally, as part of its HIFA waiver, AHCCCSA agreed to explore the feasibility of implementing a premium assistance program (employer-sponsored program - ESI) in Arizona using Title XXI as matching federal funds.

The feasibility study, conducted by AHCCCSA was divided into three components:

- A review of critical background information, e.g., federal regulations, other states' experience and current data on the working uninsured and employer-based coverage in Arizona.
- Development of a basic premium assistance model that would work best within the context of the current AHCCCS program framework and effectively meet the needs of the population being served.
- An evaluation of the pros and cons of implementing the AHCCCS designed model.

In May 2002, a final report was submitted to CMS. While the report recognized the potential role that a premium assistance program could play in the development of an accessible and affordable health care coverage system in Arizona, it was recommended that such a program not be implemented in Arizona at that time. A principle concern was that the administrative effort

and cost of implementing an ESI program did not offset the potentially small number of individuals that were expected to enroll in an ESI program. AHCCCSA decided that other efforts with Title XXI funding (e.g. expanding health care coverage to parents of Medicaid/SCHIP children) were more cost effective, reaching more needy, low-income individuals and more significantly reducing the number of uninsured in Arizona.

Despite these reservations, AHCCCSA subsequently agreed to work on designing and implementing a premium assistance program to be piloted in two counties. An internal work group was formed and charged with the task of designing a program. In February 2004, an Employer Sponsored Insurance (ESI) Pilot Program proposal was submitted to CMS for review, but was never approved. In 2006 AHCCCSA submitted a five year waiver continuation to CMS. As part of the requirements for approval, the agency is required to secure state legislative approval and implement and provide services through an ESI program by October 1, 2008.

SECTION 5. CONSENSUS BUILDING STRATEGIES

This section describes the governance structure, including methods used to obtain input from stakeholders and other activities conducted to build public awareness and support. Additionally, this section provides a brief overview of the current "policy environment" as it impacts the implementation of coverage expansion options.

GOVERNANCE STRUCTURE

The Governor of Arizona identified AHCCCSA, the state's Medicaid/SCHIP agency and overseer of Healthcare Group, as the lead project agency for the project. While AHCCCSA has remained the responsible agency for guiding and overseeing the grant activities, elements of the governance structure were modified between Phases I and II, to better meet the needs of the defined project goals for those phases.

Phase I: Development of General Plan for Coverage of Uninsured

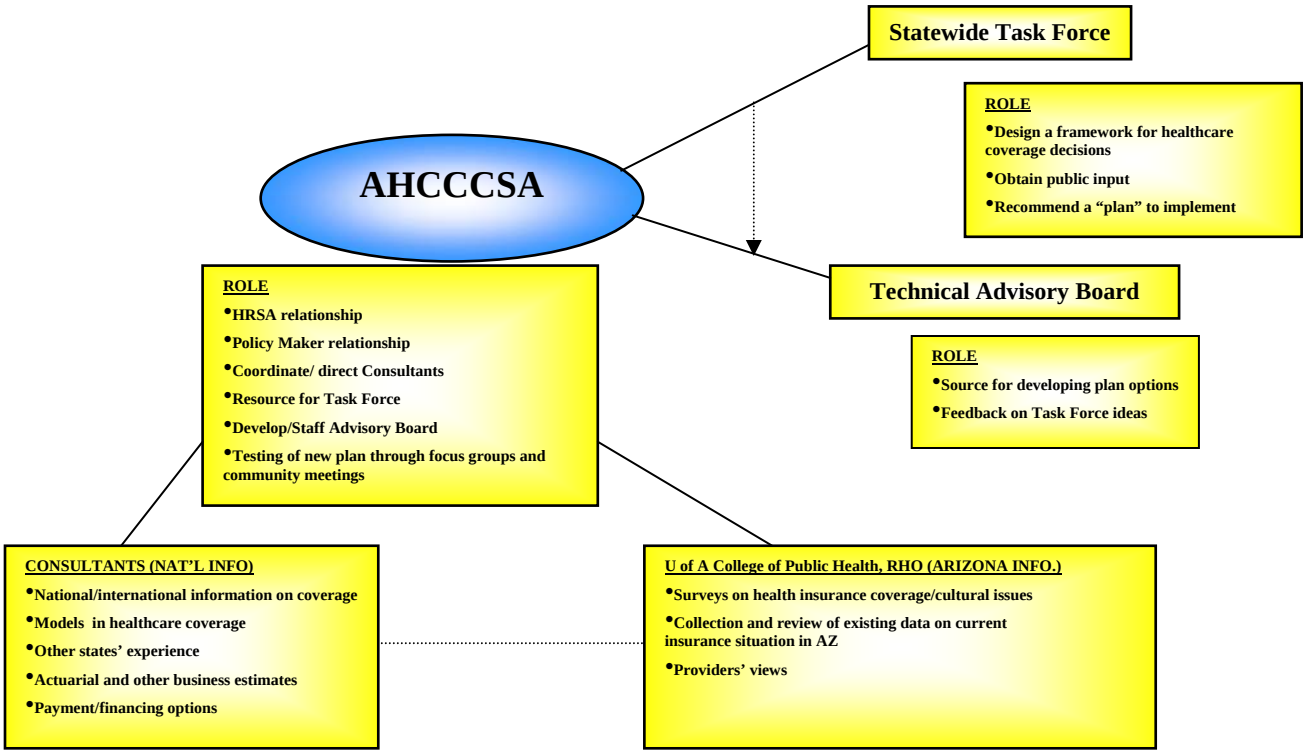
During Phase I, the governance structure AHCCCSA put in place lent itself to a process by which one was able to effectively build consensus around a coverage expansion plan, to address the issue of the uninsured in Arizona. The governance structure ensured involvement of the executive branch, the legislative branch, and a variety of key constituent groups in the planning process. A schematic of the organizational structure is set forth in Diagram 2 on next page. Key components included:

- AHCCCSA Team. The AHCCCS Director, served as the principal investigator for the project with other relevant AHCCCS staff included as part of the project team (e.g., administrator of the policy unit and the medical director). In addition to appointing a current staff person as the AHCCCS-HRSA Coordinator, two (2) new positions were established – a project administration associate and a provider relations/model development specialist. Aside from AHCCCSA staff, AHCCCSA contracted with an outside consultant to serve as the Project Director and another to serve as a facilitator for various project related meetings, e.g., Task Force meetings.

- Task Force. The Statewide Health Care Insurance Plan Task Force was a legislatively sponsored committee, charged with the responsibility of designing an accessible and affordable health care coverage plan; including the identification of recommended strategies to be implemented. There were six (6) legislators on this committee representing both rural and urban districts in the State. In addition, other key constituent groups represented on the Task Force included a health care provider, a representative of

a consumer advocacy group and a representative of the business community. These three (3) members were appointed by the Governor.

Diagram 2: Project Schema HRSA for Phase I



The Task Force held numerous meetings for which AHCCCSA played a lead role in the provision of technical assistance and staffing support. These meetings served multiple functions, allowing Task Force members to hear formal presentations by experts in the community, to receive public testimony and to discuss key issues and solutions related to the provision of accessible and affordable health care coverage in Arizona. Two key outcomes from these meetings were (see Section 4):

- The development of an agreed upon set of basic principles for health care coverage in Arizona which are intended to serve as the framework for guiding the Task Force in the formulation of final recommendations.
- Final recommendations that included a General Plan for coverage of the uninsured and supported proposed changes to Healthcare Group.

- Technical Advisory Committee (TAC). AHCCCSA created the TAC to serve in an advisory capacity to both AHCCCSA and the Statewide Health Care Insurance Plan Task Force; providing guidance in the development of the General Plan as well as feedback on proposed approaches. The TAC was composed of representatives from the physician community, insurance companies (urban/rural, commercial and specialty), hospitals (rural and urban) and state agency directors of AHCCCSA and the Department of Insurance. The TAC primarily focused on the development of strategies that "use

available, affordable, financial insurance vehicles to reduce the uninsured population that would not be eligible for public programs." Strategies they recommended to the Task Force included:

- Community-based education on the value of insurance.
- A High-risk pool using multiple funding sources (e.g., public, private and insurance premium funded).
- Ability to market flexible benefit packages that could be adapted to current marketplace demands.

Phase II: Development of Specific Coverage Options

For Phase II of the project, the organizational structure was simplified. While the key AHCCCSA SPG project staff continued to be actively involved in the project, there was more limited use of consultants with much of the work being accomplished by qualified internal AHCCCSA staff. The Technical Advisory Committee was disbanded as the new Task Force expanded its representation to include representatives from similar organizations.

AHCCCSA was fortunate in having a formalized body of decision-makers in the newly reestablished legislatively task force (i.e., Statewide Health Care Insurance Plan Task Force). As in Phase I, the Task Force was helpful in moving forward the planning efforts for addressing the issue of accessible and affordable health insurance for all Arizonans. The Governor also played a key role in ensuring the passage of needed legislation to reform Healthcare Group and continue coverage of parents of Medicaid/SCHIP children (i.e., HIFA parents).

Phase III Focus on Small Business Coverage through Healthcare Group

Due to the narrow focus of the two Continuation Grants on HCG, AHCCCSA/HCG staff oversaw the conduct of the activities. For the 2004 Continuation Grant, contracts were established to conduct surveys and focus groups. AHCCCSA contracted with SHADAC to conduct a literature review of the utilization patterns of the newly insured. For the 2005 Continuation Grant, AHCCCSA contracted with PCAP to conduct a variety of activities related to focus groups and literature reviews. A separate contract was developed to conduct the planning for enhancements to the AHCCCS web-based eligibility application tool, the Health-e-Arizona (HEA) application, to allow information on employers to be gathered at the point where applications are initiated, such as at a community health center.

STAKEHOLDER INPUT

Phase I: Development of General Plan for Coverage of Uninsured

In addition to the various constituent groups that were part of the governance structure, the Task Force provided a number of opportunities for the public to participate in the planning process. In addition to the State Planning Grant-related presentations, numerous other formal presentations were made by other local health care experts, e.g., on telemedicine and on the state employee

insurance plan. All the Task Force meetings were well attended (i.e., approximately 50 attendees) with representatives from insurance carriers, retirement groups, advocacy agencies, employee unions, hospital association, health facilities and county governments. Additionally, numerous stakeholders provided public testimony including representatives from:

- Arizona Bridge to Independent Living
- American Association of Retired Persons
- Arizona Citizen Act
- Community Physicians
- Arizona Pharmacy Association
- Arizona Interfaith / Valley Interfaith

Phase II: Development of Specific Coverage Options

During the second phase of the project, AHCCCSA actively solicited input from targeted stakeholder groups regarding the specific coverage option under consideration:

- AHCCCSA conducted extensive interviews with rural health care practitioners around the State to identify barriers that discourage providers from practicing in rural areas as well as effective strategies for further developing the rural provider network and expanding coverage to those in need.
- In order to further refine proposed HCG benefit packages and better understand issues of affordability for small businesses, meetings were held with community interest groups (e.g., Hispanic, Asian, and Afro-American business groups, local chambers of commerce, and credit unions).

Phase III Focus on Small Business Coverage through Healthcare Group

Governor's Arizona Health Coverage Policy Summit

In reply to: addition to the survey of employees and the focus groups conducted with small businesses noted in previous sections, in November 2006, at the invitation of the Governor, 135 representatives from small businesses, local chambers of commerce, insurance brokers, health plans, medical provider groups, governmental, academic and advocacy organizations from across the state met to assess healthcare coverage strategies and discuss their relevance to Arizona.

Participants were engaged for two days of interactive presentations and targeted discussions crafted to address three Summit goals: 1) Provide business and community leaders with actionable knowledge, models, and tools to advance access to affordable care in our communities; 2) Explore in-depth, with national and local experts, coverage models being used in other states; and 3) Stimulate local stakeholders to create, lead, and participate in initiatives that make healthcare coverage a reality for all Arizona small businesses and their employees.

Summit participants explored, then prioritized twenty-four health coverage options based on four general reform strategy categories: Public Program Expansions and Government-based; Business

and Individual-based; Value-based Purchasing; and Cost Control Strategies. Summit participants were optimistic about the opportunities for change in today's environment. The following actions were identified as strategies to support change:

Community Education, Awareness and Messaging:

Develop common language, better definition of issues and ongoing communication by making use of key events, meetings and common messaging.

Coalition Building:

Convene stakeholders throughout state which may include the existing communities of local action and advocacy groups highlighted during the Summit and through the on-line collaboration such as St. Luke's Health Initiative's new virtual community of practice, Arizona CAN (Coverage and Access Now).

Short Term Strategies:

Target with local advocates the "low-hanging fruit" which received support such as standardization and automation efforts; value based purchasing arrangements; and "bare period" revision efforts that would expand access to KidsCare and Healthcare Group of Arizona.

Longer Term Strategies:

Identify mechanisms to support and actively engage in the Governor's ongoing health information technology (HIT) and health information exchange (HIE) efforts. These efforts will lead to improvements in chronic care, disease prevention, and to the quality, transparency and the efficiency that can be gained from integrating evidence-based care.

OTHER PUBLIC AWARENESS STRATEGIES

In order to facilitate the public's easy access to AHCCCS-HRSA State Planning Grant information and project materials, AHCCCSA established and has continued to maintain a website (see http://www.ahcccs.state.az.us/Studies/HRSAGrantContent.asp). This website contains general descriptive information about the project, Technical Advisory Committee minutes, the policy issue papers, Task Force guiding principles, survey and focus group findings, project contacts and links to state/federal related Web sites.

In addition to the establishment of the website, AHCCCSA made numerous public presentations regarding the AHCCCSA-HRSA State Planning Grant. This included presentations at the Arizona Rural Health Conference, Arizona Community Access Program meeting, local Employee Benefit Research Institute - Consumer Health Education Council meeting on small group market, HRSA State Planning Meetings, Academy Health conference, Healthcare Financial Management Association conference, and the American Association of Healthcare Administrative Management conference.

AHCCCSA also ensured direct lines of communication with other entities/organizations with overlapping interest, e.g., Community Access Program grantees; St Luke's Initiative and Collaboration for a New Century – Health Coverage Options Subcommittee. The health Coverage Options Subcommittee used the work of the State Planning Grant to move forward their agenda to promote outreach and education, insurance for small-business and state employee insurance reform.

Current "Policy Environment"

Economic considerations, the ongoing rise in health care costs, and the balance of personal, business and government responsibility for health care coverage continue to significantly impact the type of coverage expansion strategies that realistically will be adopted in the State in the near future. For awhile, the biggest challenge for the State was to maintain the coverage expansion efforts that were successfully implemented in previous years.. While efforts to date have been successful in keeping the major program expansion initiatives, (e.g., HIFA eligible parents) some smaller programs have been eliminated or restricted (e.g., the Premium Sharing Program was repealed, with approximately 3,300 individuals losing coverage, eligibility for pregnant women was lowered from 140% of FPL to 133%, and the amount of tobacco tax monies used to support a variety of safety net programs was reduced). Recently, there have been several efforts from members of both political parties to expand coverage. In 2006, AHCCCS coverage was extended, at state-only expense, for persons who become ineligible for Medicaid due to Social Security Disability income who are not yet eligible for Medicare. Also, a bill was introduced, though not enacted, to provide near-universal coverage to all Arizonans. Political leaders and advocates continue to work on ways to expand KidsCare enrollment through outreach and possibly raising eligibility limits. While there is broad interest in watching the progress of efforts in states such as Massachusetts and California, there is currently no similar concrete proposal on the table in Arizona.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

Overall, AHCCCSA found the State Planning Grant to be an effective means for guiding and enhancing the State's policy discussion related to addressing the need for accessible and affordable health care coverage in Arizona. The end result of this effort was:

- An increased understanding of the issues surrounding health care coverage and the uninsured in Arizona.
- Development of a general framework within which to work on the development of specific policy options.
- Support to continue to further develop specific options, especially Healthcare Group.

This section discusses some of the lessons learned by Arizona through its State Planning Grant process, including recommendations to other states regarding the policy planning process itself.

DATA COLLECTION LESSONS

The State believes it was effectively able to achieve its initial project goals by relying on secondary data sources during the initial phase of its planning process. Through the compilation of this data on the uninsured and coverage in Arizona the State was the able to educate policymakers about the uninsured in Arizona and coverage issues and facilitate the development of a general coverage plan for the State. Additionally, this approach cost substantially less and required less time in its compilation than what would have been require by the collection of primary data (e.g., household surveys, and focus groups).

This same approach, however, has not proven to be as useful in the subsequent development of specific coverage options. The available secondary data is simply not able to provide the level of detail needed to be able to make well informed decisions as to how best to design and implement agreed upon coverage and expansion strategies. For example, county-specific information on the number of uninsured by county would have been useful in deciding which counties to select for the premium assistance pilot program and developing affordable small group products that would appeal to low-income individuals would be easier if information was readily available on the characteristics of the uninsured who are employed at small size firms both at a state level as well as county level. Through the State Planning Continuation Grants, AHCCCSA was able to conduct a series of focus groups and a survey to obtain a more in-depth understanding of the working uninsured in various parts of the state. Historically, little information was known about the working uninsured at a County level, and although the results of this survey did not address the differences between all counties (because of insufficient response rate), it did address some of the major differences between Arizona's three largest cities: Phoenix, Tucson, and Flagstaff. While the information did not show large differences for most factors on a county by county

basis, knowing the differences that do exist will help in the development of products and marketing activities.

ORGANIZATION AND CONSENSUS BUILDING LESSONS

AHCCCSA believes the project organizational structure that it put in place for the initial planning effort was very effective in achieving the project goals. Due to the complex nature of the subject, education of the Task Force members as well as the public prove to be a critical component in developing the General Plan for coverage of the uninsured. The approach of using both a legislative-based Task Force and the Technical Advisory Committee provided a good balance between the political decision-making process and more expertise-based decision making. Having the legislative involvement from the beginning also made it much easier to get immediate support for continuing the planning effort beyond the grant period and to ensure passage of legislation which supported the Task Force recommendations.

While there was little resistance by stakeholder groups to the high-level strategies proposed by the Task Force for addressing accessible and affordable coverage in the State, the further development of specific options clearly requires greater effort devoted to building the stakeholder support necessary to ensure final implementation of the efforts. Over the years there has been concern from the commercial insurance carriers that HCG was taking away business. Current statutes are in place only through the active involvement of the Governor and key policymakers in the Legislature, continued support of HCG members and providers, and a series of meetings with concerned stakeholder groups.

In order to develop health plans and insurance options that are attractive and affordable for the working uninsured, it is necessary to understand who this population is, what they need, and what they can afford. A number of groups have studied the Arizona uninsured on the statewide level, but few have studied the issue at a county level. Arizona supports a number of large metropolitan centers in the central and southern counties that support large, comprehensive delivery systems. The remote southeasterly counties and the northern counties, however, are almost exclusively rural. The needs of these disparate populations are not homogenous. The Continuation Grants gave Arizona an opportunity to collect data and interact at a more in-depth level with local employers and employees.

In 2004, a coalition of Tucson and Southern Arizona based hospitals, community service agencies, safety-net health providers, business leaders, physicians and consumers formed to determine ways in which access to health care services could be expanded to Southern Arizona residents without health insurance coverage and to people who find themselves under-insured. AHCCCSA and the Coalition joined together for a 2005 Continuation Grant. To maximize coordination for the grant project in Pima and Santa Cruz counties, AHCCCSA contracted with the Pima Community Access Plan (PCAP) to oversee a variety of activities, including a literature review and focus groups.

The Coalition developed strong bonds. As work on the Grant was drawing to a close, the Coalition was well-positioned to move into another key area of health, that of health information exchange (HIE). Members of the original Coalition have since created the Southern Arizona

Health Information Exchange (SAHIE), which developed a business plan to be totally self-sustaining. SAHIE's goals include enhancing the continuum of care to Southern Arizona residents, facilitate the sharing of patient information throughout the region's healthcare delivery system, and facilitate healthcare access.

IMPACT OF EXPANDING COVERAGE

The long term social and economic benefits of providing health coverage must take into account the short-term financial impact of providing care to persons who may not previously have had access to health care. Various studies have reported significant utilization spikes (also called "pent-up demand") in pharmacy and primary care services among people receiving health insurance for the first time, or after a long period of being uninsured. Most of these studies have focused on populations that qualify for federal and state programs such as Medicaid and CHIP. The small employer group population that Healthcare Group (HCG) serves does not generally qualify for these programs.

To evaluate the potential for pent-up demand among newly enrolled members (and subsequently adjust premiums to compensate), HCG contracted with SHADAC to perform a literature review on the topic of pent-up demand, with specific interest in how the phenomenon varies by the characteristics of the individual and the coverage mechanisms. The literature review was completed in August 2005.

The study cites examples of pent-up demand in Medicaid populations, and among certain socio demographic classes, but does not draw any conclusions related to the small business employee. Nevertheless, the SHADAC study did report that when excess demand was observed during the first year of insurance it had disappeared by the second year of coverage ("Pent-up Demand for Health Care Services Among the Newly Insured," The State Health Access Data Assistance Center (SHADAC), August 2005). This finding alone is encouraging news for HCG. The SHADAC report found that for some lower income people, the availability of health insurance resulted in increased utilization of preventive care and prescription drugs as compared to the general insured population. This finding is particularly important for Healthcare Group in that at least a third of the working uninsured in the state are considered lower income (i.e., less than 250% FPL). Since Healthcare Group was in the midst of a statewide expansion, the SHADAC report helped the program develop appropriate benefits and adjust premiums and reserves prospectively to prepare for these utilization spikes.

RECOMMENDATIONS RELATED TO POLICY PLANNING PROCESS

Other recommendations related to the policy planning process AHCCCSA believes are important for states to consider include:

- Prior to determining information to be collected or issues to be researched, conduct a thorough-review of the information (e.g., reports, surveys) that is already available both

nationally and locally. There is a surprising amount of data and information out there on the subject, some of which has simply not been well publicized.

- Take advantage of the technical resources that are available through the State Planning Grant (e.g., Academy for Health Services Research and Health Policy, State Health Access Data Assistance Center) as well as the knowledge and work of the other State Planning Grant states.
- Be realistic about what one can accomplish in a year, everything takes longer than expected.
- Be sensitive to the political climate, adjusting project goals to accommodate changes in the policy-making environment.
- Think carefully about what data is really needed to support the planning effort. There is an abundance of information that is "nice" to know but may not be directly helpful in furthering the State's planning efforts.
- Consider a multi-year phase-in rather than tackling the entire problem of the uninsured all at once.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

It is important for the Federal government to continue to work in partnership with the states in the development of effective strategies for addressing the uninsured. In this partnership, the Federal Government should:

- Allow states more flexibility in the design and operation of Medicaid and SCHIP.
- Provide federal financial support for coverage expansions such as subsidies for low-income individuals.
- Expand the level of state specific information that is collected by the Federal Government on coverage related issues, ensuring the information is timely and readily accessible to the states.
- Continue to fund state research on the uninsured including the development of strategies to prevent erosion of current coverage programs. For example, it is critical to continue the SCHIP program and provide maximum flexibility to states.
- Expand the use of future grant funds beyond planning and design to enable implementation and evaluation. Years of research have now been completed and states are ready to implement. However, start-up operational funding is needed, and grant dollars would be helpful to enable states to test certain coverage options.
- Consider grant funding for a similar program on the issue of the growing number of "underinsured elderly" who are in need of long term care services.

Only with a strong federal-state partnership will the issue of health care coverage in Arizona and the nation as a whole be effectively addressed.

SECTION 8. OVERALL ASSESSMENTS OF SPG PROGRAM ACTIVITY

8.1 What is the likely impact of program activities in the near future? What were the major impediments and facilitators for improved outcomes? Include specifics about changes in budgetary environment, changes in political leadership etc.

The cumulative effect of SPG activities was to create an impetus and added credibility and focus to state coverage expansion efforts. As discussions increase at both the state and national levels, the efforts of SPG activities will help support Arizona specific policies. The grant began with efforts to broadly paint a picture of health coverage throughout the state and culminated in November 2006 with the 2-day Arizona Governor's Summit*: Building Affordable Health Care Options for Small Business.* The conference provided an opportunity to aggregate, summarize and craft a fresh approach to coverage challenges. Among other outcomes, the Summit produced four policy recommendations to increase health coverage, including recommendations to eliminate existing barriers to small business health coverage options. Arizona's Legislature is currently considering statute changes that could increase the number of people with coverage. In addition, over the life of the grant, core stakeholders have continually participated in various activities that have helped maintain a sense of continuity in addressing the challenges and opportunities inherent in expanding coverage. Advocacy will continue in response to increasing pressures to find solutions to the growing number of uninsured Arizonans.

SPG activities have also been beneficial as the state moves forward with electronic health technology. There will be continued efforts to expand the Health-e-Arizona (HeA) universal electronic application system to include direct links that enable easier enrollment and data sharing for those seeking health coverage. Previously, applicants for public health coverage programs such as Medicaid, were channeled to the Arizona Department of Economic Security. With the development of the HeA electronic universal application process, residents increasingly have a greater choice where they are able to apply for services and obtain faster coverage determinations. In addition, partnerships have formed among those involved in SPG efforts to position the state to successfully develop health information exchange, electronic health records and transparency.

Facilitators to change have been the increasing pressures, primarily cost related, making it more difficult for businesses to provide insurance coverage. Results from focus groups organized with SPG support show that the pressure to eliminate or reduce health coverage is growing and is becoming especially intense for small businesses.

Major challenges to expansion include budget downturns, concern about making future financial commitments as the economic picture improves, and the interplay among stakeholders such as state operated coverage programs (Medicaid, KidsCare, Healthcare Group), commercial insurers, employers, and providers.

8.2 What is the state's current view of most feasible expansion options? What direction was deemed most feasible and why?

There is currently not a consensus about how to address coverage issues at either a national or state level. Arizona's Governor has declared increasing children's coverage as a priority of her administration. Several statutory changes are being considered by the Arizona State Legislature. There are also grassroots efforts underway to develop a voter initiative for universal health coverage.

8.3 What do you foresee to be the sustainability of programs implemented as a result of the SPG program, or the likelihood that programs currently under consideration will be implemented?

Arizona's Medicaid program (AHCCCS) has the mission to*: Reach across Arizona to provide comprehensive, quality health care for those in need*. The maintenance and extension of SPG-related activities will continue through AHCCCS and the numerous community partnerships developed with SPG support. In addition to the continued efforts to provide affordable coverage to the working uninsured through Healthcare Group, AHCCCS' commitment to expanded coverage includes the establishment of an operational "home" to the HeA universal electronic application system.

8.4 Did your SPG program activity create an impetus to change your state's Medicaid program via a waiver, changes in eligibility or cost-sharing?

Arizona has an 1115 demonstration waiver under which it operates its entire Medicaid program, which was renewed for five years beginning October 2006. The waiver allows the state to run its unique and successful Medicaid managed care model. Although information gathered over the life of the grant was helpful in preparing the waiver renewal, SPG activities did not directly lead to changes in waivers, eligibility or cost sharing.

8.5 Please describe the realities of state decision-making regarding insurance expansion in terms of things that facilitate and inhibit policy changes.

Two key factors affect state decision-making about insurance expansion: (1) State budget and financial standing, and (2) A philosophy of public verses private accountability in ensuring health coverage. The first issue seems evident, the State only considers health coverage in the context of "affordability"; what can the state budget withstand? However, there is a broader issue, articulated well in the SPG Focus Group Report. There is a discrepancy observable both in public discourse and among state legislators, about the ideal role of government in ensuring coverage. While there is general agreement that a health care coverage crisis currently exists, and that coverage problems are getting worse, there is little agreement about how to fix the problem and the role of government in so doing. Even during periods of budget sufficiency, which has been the case in Arizona since 2004, there have been no recent significant expansions of the state's role in providing health care coverage.

There is also the reality of the varied interests of key players in the health coverage environment, such as state operated coverage programs (Medicaid, KidsCare, Healthcare Group), commercial insurers, employers, and providers.

8.6 Concretely, what was the value of the funding data collection analysis? How were the results used to shape political thinking and build consensus on ways to cover the uninsured? What is the value of data being re-collected and at what frequency?

The original SPG afforded Arizona an unprecedented opportunity to conduct a comprehensive scan of coverage options and attitudes. The formal reports that were prepared were referenced widely by a legislative study committee and have continued to be a resource for health coverage policy discussions. In Phase III, data was gathered in two ways: compiling existing service information to create a health service Directory of relevance to small businesses; and (2) focus groups among small business owners and managers to identify existing coverage barriers and support for state policies to expand coverage.

The data collected have been very helpful in documenting the conditions of insurance coverage in Arizona. An ideal strategy would be to collect and analyze data on an ongoing basis to validate existing information and to document longitudinal trends as long as specific dissemination strategies are incorporated as part of the data collection design. A local foundation-led organization has been established to facilitate and foster coordinated data collection, retrieval and information generation for the development of future state health policy.

Information from the SPG-funded activities was recently used in an Arizona Town Hall on Health Care. The organization, which has a five-decade history, meets twice yearly to address topics of importance to the state, from transportation to water to health. One hundred and thirty-six diverse Arizonans representing a wide variety of perspectives on the health care debate continuum met to have substantive debate and prepare a consensus report on health care accessibility, affordability and accountability. The Town Hall background paper and final report can be read at www.aztownhall.org.

8.7 In terms of the data collection activities pursued through the SPG grant, are there certain ones you would do differently based on experience?

Efforts to increase the participation rates of small businesses in data collection efforts are needed. Even with financial incentives provided to encourage business participation, we did not achieve high enough participation rates.

8.8 How have stakeholder groups evolved over time? In hindsight, what are the central components to putting and keeping together a successful steering committee?

As coverage problems are becoming more widespread and severe, it becomes easier to document need and coverage problems and to recruit stakeholders willing to participate in limited advocacy and education programs. Efforts that require ongoing group member support should focus on immediately achievable outcomes. It is critical that stakeholders from a wide variety of interests

participate if change is to occur, including consumers, legislators, business leaders and government entities. The SPG grant was very useful for maintaining a focus among a wide variety of government, health care and business interests in addressing the issue of the uninsured. The stakeholder group evolved over time. Arizona's experience would show that it is important to not establish a rigid steering committee structure.

8.9 What activities will be discontinued as a result of the SPG grant coming to a close?

Grant budget oversight and progress reporting functions will discontinue. Specific coverage-related data collection and publication efforts will be reduced.

8.10 Highlight specific lessons about potential policy options that could be used by HHS and states to shape future activities.

The development of an electronic universal coverage and service application system (Health-e-Arizona, or HeA) fits well into HHS' four pillars approach to health system transformation. Arizona's small business coverage program, Healthcare Group, offers a series of unique insights into a public-private approach to employer-based health coverage with Medicaid agency oversight.

8.11 Please comment on how helpful the site visit, availability to talk/email with Academy Health staff, and general technical assistance of Academy Health was to your project?

The personal, telephonic and virtual exchanges with Academy Health staff have provided timely, useful technical assistance which was always delivered with collegiality and enthusiasm.

8.12 Please comment on how helpful the HRSA SPG grantee meetings were to your project?

HRSA SPG grantee meetings were invaluable to Arizona's project plans and outcomes, while fostering the professional development of the state's leaders. Productive use of the featured experts and resources as well as networking utilization increased exponentially in the later (continuation) project phases. The interface with AcademyHealth, SHADAC, and later, RWJF, as well as the sharing (in-person and virtually) between and amongst sister grantees yielded speakers, topics and structure for internal and external meetings and plans. Answering the sometimes probing questions from fellow grantees really helped Arizona examine its own policies and processes in several key benefit design and reinsurance areas. The academic content was consistently reported as "rich", and the real-life examples and discussion as juxtaposed during the meetings "insightful." . Finally the exposure to the other AcademyHealth programs, polls and research proved valuable as well.

8.13 Please comment on how helpful the technical assistance from SHADAC was to your project?

SHADAC staff provided both formal and informal technical assistance during data collection and survey efforts. Their assistance was timely and beneficial. The report they prepared on

utilization patterns of the newly insured was done in a thorough and professional manner, on time, and well within the budget. We would highly recommend SHADAC for future projects.

8.14 Please comment on how helpful the Arkansas Multi-State Integrated Database System was to your project, (if applicable).

Arizona did not use this tool.

8.15 Please comment on how useful the Agency for Healthcare Research and Quality's technical assistance and survey work (e.g. MEPS-IC) was to your project.

The MEPS-IC was extremely useful in developing a better understanding of employer based coverage in Arizona and to trend changes over time. It also enabled a comparison of Arizona both to other states and the nation as a whole. The data is very user-friendly.

8.16 Please comment on the long-term effect (if any) of your state's SPG program on future efforts to improve coverage via:

a. Data collection - e.g. surveys, focus groups, etc.
b. Data analysis – e.g. modeling, actuarial analysis
c. Political understanding/education
d. Approaches and structure for collaboration

Arizona has been fortunate to receive three HRSA State Planning Grants during different funding cycles. Phases I and II were instrumental in establishing a knowledge baseline of healthcare coverage and Arizona's uninsured populations. They were also critical to supporting the work of the Arizona Legislature's Health Coverage Committee. Unfortunately, though the Committee met as required, the State's budget shortages during the early 2000s did not support any major expansion efforts. Phase III funding provided useful information from the uninsured about their experience and extant demand for products and services. Efforts funded with the Continuation grants provided new information from small businesses about barriers to health coverage and support for public policy to expand coverage. The grant also enabled the planning and design of a method to directly link the health-e-Arizona universal coverage application system to the state's small business health coverage program, Healthcare Group. In Arizona, there exists a general agreement that serious health coverage problems exist and that the health care system is "broken". However, at both the state and national levels, there remains a great deal of diversity in terms of opinion and policy preferences when considering how to best "fix" the system and achieve coverage.

APPENDIX I: BASELINE INFORMATION

Population

The U.S. Census Bureau, 2006 population estimates for Arizona in 2006 was 6,166,318.[46] Arizona's population increased 3.6% between 2005 and 2006, the highest percentage change among all states.

Number and Percentage of Uninsured (Current and Trend)

According to the U.S. Census Bureau 2006 Current Population Report, Arizona's overall rate of uninsurance was 18.7% in 2004-2005.[47] After decreasing substantially between 1998 and 2000, the percentage of uninsured in Arizona for all ages has increased the past three years (see Table 1 in Section 1).

Average Age of Population

As reported by the American Community Survey Profile 2005, the median age in Arizona was 34.5 years.[48] Twenty-seven percent of the population were under 18 years and 12.6% were 65 years and older.

Percent of Population Living in Poverty (<100% of FPL)

In 2005 according to the American Community Survey Profile, 14.2% of all Arizonans had incomes in the past 12 months that were below the poverty level (i.e., incomes less than 100% of FPL).[49] Additional analysis showed:

- 19.9% of related children under 18 were below the poverty level,
- 8.2% of people age 65 and over were below poverty level
- 10.9% of all families were below poverty level
- 28.4% of female householder families, no husband present, were below poverty level.

Primary Industries

In 2005 according to the American Community Survey Profile, for the civilian employed population 16 years and older, the leading industries in Arizona were:[50]

- Education, health and social services (19%)
- Retail trade (12%)
- Construction; and professional, scientific, and management, and administrative and waste management services (each at 11%)
- Arts, entertainment, and recreation, and accommodation, and food services (10%)

Seventy-nine percent of the people employed were private wage and salary workers, 15% were government workers and 6% were self-employed. The three most common occupations were: management, professional and related occupations (33%); sales and office occupations (27%) and service occupations (17%).

Number and Percent of Employers Offering Coverage

The 2004 Medical Expenditure Panel Survey – Insurance Component reported, there were 103,397 private-sector establishments in Arizona of which 56.1% (58,006) offered health insurance.[51] For firms with less then 50 employees only 39% of the establishments offered health insurance and for firms with 50 or more employees 92.8% offered health insurance.

Number and Percent of Self-Insured Firms

The 2004 Medical Expenditure Panel Survey – Insurance Component reported, there were 103,397 private-sector establishments in Arizona. Of the 58,006 private-sector establishments that offered health insurance, 36.3% (21,055) offered health insurance that self-insure at least one plan.[52]

Payer Mix

The pooled 2004 and 2005 Current Population Surveys showed the population distribution by insurance status (i.e., payer mix) for Arizona as follows:[53]

- 46% - Employer
- 5% - Individual
- 16% - Medicaid[54]
- 13% - Medicare
- 1% - Other Public
- 19% - Uninsured

Provider Competition

Arizona's rapid population growth is placing significant pressure on its current health care infrastructure, leading to provider shortages and reduced provider competition in many areas of the State (see Section 3 under Health Care Infrastructure). While the costs for premiums has continued to increase, the number of health plans participating in the group market as well as in AHCCCS and Medicare Advantage has remained relatively stable. The urban areas of the State afford consumers both a larger choice of plans and products, with many rural parts of the State being dominated by a single plan and limited to non-HMO coverage options.

The Winter 2001, Summer 2003 and September 2005, *Community Tracking Reports*[55] reported on emerging provider trends among hospitals, physicians, and health plans in the Phoenix market, much of which is applicable to the State as a whole.

- National firms now control the majority of the Phoenix community's hospital capacity and dominate the health plan market.
- Along with building new emergency rooms and reconfiguring existing inpatient capacity, hospitals are building new hospitals in outlying communities and upgrading and expanding existing facilities in older sections of the city. Despite these efforts hospital construction in Phoenix has not kept up the demands of the rapidly increasing population.
- Despite a shift in care to outpatient setting, competition between general hospitals and physicians remains muted by the health care system's capacity constraints.
- With provider capacity failing to keep pace with population growth, providers are more willing to walk away from contracts that do not pay what they want, making it more difficult for health plans to negotiate smaller payment increases, particularly with hospitals and to keep providers in their networks.

Insurance Market Reforms

Health care insurance reforms that have occurred in Arizona over the past 13 years include:

- In 1993, the legislature enacted the Accountable Health Plan Law, which was aimed at improving the availability of group health insurance to small-employers. Effective January 1, 1994, group health insurers (Accountable Health Plans) were required to offer at least a basic health benefits plan to employers, including small-employers. The legislation phased in elements of guaranteed issue with later effective dates. Specifically, effective July 1, 1994 an Accountable Health Plan was required to make the basic health benefits plan available to employers with 25 to 40 employees who had been without coverage for at least 90 days. Effective July 1, 1996, an Accountable Health Plan was required to make the basic health benefits plan available to employers with three (3) to 40 employees who had been without coverage for at least 90 days.

- While the 1993 legislation improved the availability of group health insurance to small-employers, it only provided such coverage on a guaranteed issue basis for a certain small-employers and their employees. Legislation that became effective July 1, 1997 required an Accountable Health Plan to provide a health benefits plan, without regard to health status-related factors, to any small-employer who agreed to make the required premium payments. As part of this legislation the definition of "small-employer" was revised to include any employer with two (2) but not more than 50 employees, the basic health benefit plan was eliminated and all small-employers are entitled to guaranteed issue, not just those that have been without coverage for at least 90 days. This legislation conformed to federal guaranteed availability requirements established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- In 1996 another aspect of small-employer market reform was enacted, granting a premium tax exemption for Accountable Health Plans for reported small group premiums. (All insurers in the state including Accountable Health Plans must pay a two percent tax on their premiums). Some Accountable Health Plans have determined that

the tax savings is not worth the administrative cost of breaking out the small-employer premiums and do not claim the exemption.

- In 2000 the Arizona legislature passed legislation restructuring the regulatory oversight of managed care organizations with DOI having oversight of medical service delivery by HMOs and dental service delivery by prepaid dental plan organization, mandating additional health care benefits (e.g., off label use of drugs for cancer treatment, direct access to chiropractic services) and establishing timely pay and grievance standards for payment of health care providers.

- In 2003 DOI was given the legislative authority to improve rate stability in the long term care insurance market, giving DOI the authority to approve and disapprove rates and regulate non-forfeiture benefits associated with long term care insurance.

- In order to address the issue of affordable health insurance coverage, legislation was passed in 2005 to clearly allow health care insurers to offer health benefit plans that contain a choice of deductibles, coinsurance, co-payments, out-of-pocket and other cost sharing levels (e.g., a high deductible plan).

- Two bills were passed in 2006 that addressed health insurance coverage in the small employer market. The first bill (HB 2698) exempts small business health insurance plans (2 to 25 employees) from complying with certain insurer mandates, including but not limited to any surgical services, maternity benefits, chiropractic services, coverage of medical foods to treat metabolic disorders and drug or devices for contraception or outpatient contraception services. The second bill (HB2177) establishes a premium tax credit for individual and small business health insurance (e.g., lesser of $1,000 for single coverage or $3,000 for family or 50% of the health insurance premium). The maximum amount of tax credit allowed is $5 million per calendar year.

Eligibility for Existing Coverage Programs

Diagram 3 below shows eligibility levels for income-based AHCCCS programs:[56]

Diagram 3: Eligibility Levels for AHCCCS Programs

<table>
<tr><td colspan="2">Temporary Medical Coverage Program (Recipients of Social Security Disability Insurance who are no longer eligible for AHCCCS but are not yet eligible for Medicare – monthly premium based on income)</td><td></td></tr>
<tr><td colspan="2">Young Adult Transitional (18 – 21 years who were children in foster care when they turned 18; no income limit)</td><td></td></tr>
<tr><td>Ticket to Work (limited to disabled, 16 – 65 years, returning to work – allows them to retain Medicaid benefits)</td><td>Breast and Cervical Program (under 65 and ineligible for other forms of Medicaid)</td><td>--250% FPL</td></tr>
<tr><td colspan="2">Arizona Long Term Care Program (300% of Federal Benefit Rate [equivalent to 228% FPL] and at risk for institutionalization.)</td><td>--228% FPL</td></tr>
</table>

Title XXI (SHCIP): ▪ KidsCare (limited to children under 19 years) ▪ Parents of KidsCare or Title XIX children (limited to availability of funds)				--200% FPL
Transitional Medical Assistance (TMA)				--185% FPL
AHCCCS Medicaid – Children Under Age 1 (SOBRA)				--140% FPL
Medicare Cost Sharing Program (up to 135% of FPL depending on the program				--135% FPL
AHCCCS Medicaid – Pregnant Women and Children Ages 1 – 5 (SOBRA)				--133% FPL
AHCCCS Medicaid – Various Programs Based on Income (Prop 204/Title XIX Wavier)	Families and Children 1931	AHCCCS Medicaid – Children Ages 6 - 18	Supplemental Security Income (SSI) Limited	--100% FPL
AHCCCS Medicaid – Spend-down group (medical expense reduce gross income to 40% of FPL)				--40% FPL

Use of Federal Waivers

Arizona became the last state in the nation to implement a Medicaid program. In October 1982, Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS) was started under an 1115 Research and Demonstration Waiver granted by the Health Care Financing Administration (HCFA). The following Medicaid services were phased-in between 1982 and 1990:

- From 1982 until 1988, AHCCCS only covered acute care services, except for a 90-day, post-hospital skilled nursing facility coverage.
- In 1988, a five (5) year extension of the program was approved by HCFA to allow Arizona to implement a capitated long-term care program called the Arizona Long Term Care System for the elderly, physically disabled, and developmentally disabled populations.
- In 1990, AHCCCS began offering comprehensive behavioral health services, eventually extending behavioral coverage to all Medicaid eligible persons over the next five years.

Since 1990, a number of waiver extensions and amendments have been approved.

- In January 2001, coverage under Title XIX was expanded to include individuals with income at or below 100 % of FPL and individuals who incur medical bills sufficient to reduce their income to 40% of FPL. The approved waiver amendment was the result of a ballot initiative.
- In December 2001, the demonstration waiver was extended until September 30, 2006.

A Health Insurance Flexibility and Accountability (HIFA) waiver was approved by Center for Medicare and Medicaid Services (CMS) in 2002 allowing:

- Coverage of parents of Medicaid and SCHIP children with family incomes between 100 to 200% of FPL (implemented October 1, 2002).
- Limited approval to use Title XXI funds for adults over 18 without dependent children with income at or below 100 % of FPL. The State may only use the Title XXI funds for the expansion population as long as sufficient Title XXI funding is available for SCHIP children and parents.

Arizona's Section 1115 demonstration waiver was renewed by CMS for a five year period beginning October 25, 2006. Arizona's 1115 Waiver allows the state to run its unique and successful Medicaid managed care model by exempting Arizona from certain provisions of the Social Security Act and includes expenditure authority to allow reimbursement for costs that would not otherwise be receive Federal matching funds.

Under the 2006 renewal, all existing authority was approved with additional authority for new programs and processes. For the first time, the ALTCS portion of the demonstration was included in budget neutrality. New authority was granted to allow Arizona to: reimburse spouses who meet certain criteria to serve as caregivers to eligible ALTCS enrollees who receive Home and Community Based Services; impose cost sharing on households with children under the age of 18 who have developmental disabilities and are enrolled in ALTCS when the parent's annual adjusted gross income is at or exceeds 400% of the FPL (legislative mandate); and increase premiums for parents of KidsCare children (legislative mandate). As part of the renewal, Arizona must implement an Employer Sponsored Insurance program by October 1, 2008. In addition, Federal Financial Participation will be phased down for services to enrollees ages 21-64 residing in Institutions for Mental Disease for the first 30 days of an inpatient episode and Arizona must utilize Certified Public Expenditures as the funding stream for public hospitals who receive funding for disproportionate share hospitals.

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

The key Web Site to use for additional sources of information regarding the AHCCCS-HRSA State Planning Grants is http://www.ahcccs.state.az.us/Studies/HRSAGrantContent.asp.

In addition for more information about Healthcare Group of Arizona (HCG) use the HCG Web Site at http://www.healthcaregroupaz.com.

APPENDIX III: SPG SUMMARY OF POLICY OPTIONS

Option considered	Target Population	Estimated Number of People Served	Status of approval (for example waivers submitted or legislation proposed) Please provide month and year when waiver or legislation was proposed and if approved, month and year of approval	Status of implementation (please include month and year program or initiative began)	If implemented, most recent estimate within the federal fiscal year (Oct.1 – Sept 30) of number people served. Please provide the month and date of the point in time estimate provided.
1 .Enhance Healthcare Group	Working uninsured in small businesses, including the self-employed	100,000 +	N/A	Modifications to existing program made throughout 2004 – 2006	Number of insured increased from 11,102 in March 2004 to 26,062 in March 2007, an increase of 14,960 people or 135% growth.
2. Premium Assistance Program	Title XIX/XXI working families with access to employer-sponsored coverage	Unknown	Waiver approval October 2006	Workgroup formed to design program	Not yet implemented

ENDNOTES

[1] AHCCCSA was awarded two separate $150,000 continuation planning grants to develop strategies for improving and expanding affordable coverage to employees of small group employers.

[2]Copies of these reports can be found on the AHCCCS-HRSA State Planning Grant website at http://www.ahcccs.state.az.us/Studies/HRSAGrantContent.asp.

[3] This is based on a 2 year average 2004 – 2005. See *Income, Poverty and Health Insurance Coverage in the United States: 2005.* Current Population Reports by Carmen DeNavas-Walt, Bernadette D. Proctor and Cheryl Hill Lee from U.S. Census Bureau (Issued August 2006); available from http://www.census.gov.

[4] From Mercer, Inc analysis presented to Statewide Health Care Insurance Plan Task Force on September 27, 2001. Kaiser Commission on Medicaid and the Uninsured also found in 2002 similar trends nationally with the 55 to 64 age group representing 9% of non-elderly uninsured adults and the 19 to 34 age group representing 53% of all non-elderly uninsured adults.

[5] Monitoring the Health Care Safety Net: Book I A Data Book for Metropolitan Areas, Agency for Healthcare Research and Quality, 2003.

[6] *Kids Count 2006 Data Book Online*. Ann E. Casey Foundation. http://www.aecf.org.

[7] United Health Foundation, America's Health: State Health Rankings – 2006 Edition. http://www.unitedhealthfoundation.org.

[8] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2004 Medical Expenditure Panel Survey – Insurance Component. http://www.meps.ahrq.gov. In 2002, 87% of private sector firms offered coverage, 74% of the employees were eligible for health insurance and 82% had enrolled in coverage.

[9] Mercer, Inc. July 2001. Faces of the Uninsured and State Strategies to Meet their Needs: A Briefing Paper.

[10] A recent Kaiser Daily Health Policy Report (1/20/07) reported that an estimated quarter of uninsured U.S. residents are eligible but not enrolled in public health insurance programs.

[11] U.S. Census Bureau. American FactFinder – Arizona. http://factfinder.census.gov

[12] For 2004-2005 Kaiser reported that there was not sufficient data for reporting the rate of non-elderly uninsured among Blacks and other racial/ethnic groups, but for 2001-2002 they report the rate of non-elderly uninsured as 21% for Blacks and 23% for other racial/ethnic groups.

[13] Pew Hispanic Center. April 26, 2006. *Fact Sheet: Estimates of the Unauthorized Migrant Population for States based on the March 2005 CPS.* http://www.pewhispanic.org

[14] Kaiser Commission on Medicaid and the Uninsured. June 2004. *Immigrants and Health Coverage: A Primer*. http://www.kff.org.

[15] Rhoades, Jeffrey and Steven Cohen. August 2006. *The Long-Term Uninsured in America, 2001-2004: Estimates for the U.S. Population under Age 65.* MEPS, Agency for Healthcare Research and Quality.

[16] *Squeezing the Rock: Maricopa County's Health Safety Net*. Arizona Health Futures, St. Luke's Health Initiatives. Winter 2002 and May 2006; available from http://www.slhi.org/ahf/studies.

[17] Arizona Association of Community Health Centers March 2007 update to November 26, 2001 presentation to the State Health Care Insurance Plan Task Force.

[18] State Health Access Data Assistance Center. June 2004. *SHADAC State Health Access Profile: Arizona* http://www.shadac.org/analysis/stateprofiles.asp#A.

[19] The actual figure for uncompensated care may be higher since not all hospitals reported the data.

[20] Copies of these reports can be found on the AHCCCS-HRSA State Planning Grant website at http://www.ahcccs.state.az.us/Studies/HRSAGrantContent.asp.

[21] U.S. Census Bureau. *American Community Survey Profile 2005*. http://www.census.gov/acs.

[22] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2004 Medical Expenditure Panel Survey – Insurance Component. http://www.meps.ahrq.gov.

[23] U.S. Census Bureau. *American Community Survey Profile 2005*. http://www.census.gov/acs.

[24] September 2006 data released by U.S. Department of Commerce, Bureau of Economic Analysis and prepared by Bureau of Business and Economic Research, University of New Mexico.

[25] U.S. Census Bureau. *Health Insurance Coverage Status and Type of Coverage by State: All People: 1987 to 2005.* http://www.census.gov/hhes/hlthins/historic/hihistt4.html.

[26] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2004 Medical Expenditure Panel Survey – Insurance Component. http://www.meps.ahrq.gov

[27] *Number of Businesses in Arizona.* May 2002. Published in partnership between Arizona Department of Commerce and the ASU College of Business, Center for the Advancement of Small Business.

[28] The four wage quartiles each represent 25% of the total U.S. employment for private-sector establishments. Establishments in the lowest of the four quartiles (1st quartile) have lower average payrolls per employee (compensation excluding fringe benefits) than any establishments in the other quartiles.

[29] WestGroup Research. *Small-Business Survey Arizona 2000* prepared for Arizona Hospital and Healthcare Association, Arizona Chamber of Commerce, Blue Cross and Blue Shield of Arizona and St. Luke's Charitable Health Trust. http://www.azhha.org/public/pdf/small_bus_full_rpt.pdf.

[30] Kaiser Daily Health Policy Report from September 28, 2004 reported on a new poll completed by Behavior Research Center of 400 small businesses in Maricopa County. The survey found that only 44% of small businesses could afford to offer employee health benefits, down from 52% in 2000 and 57% in 1996.

[31] Ibid

[32] Arizona Department of Insurance. 2002. Triennial Report Regarding the Accountable Health Plan Laws.

[33] These briefs are discussed later in this Section and in addition copies of these briefs can be found on the AHCCCS-HRSA State Planning Grant website at http://www.ahcccs.state.az.us/Studies/HRSAGrantContent.asp

[34] These two diagrams have been updated to reflect the current AHCCCS eligibility categories and the current Federal Poverty Levels.

[35] AHCCCS Population by Contractor (2005 – 2006) and U.S. Census Bureau population estimates for July 1, 2006.

[36] Trude, Sally., et. al. September 2005. *Rapid Population Growth Outpaces Phoenix's Health Care Capacity*. Community Report No 6. Center for Studying Health System Change. http://www.hschange.org.

[37] Kaiser Family Foundation State Health Facts Online. *State HMO Penetration Rate, July 2005.* http://www.statehealthfacts.org.

[38] Arizona Department of Insurance. 2002. Triennial Report Regarding the Accountable Health Plan Laws.

[39] Arizona Department of Insurance. May 2006. *Report on Arizona Health Insurance.* http://www.id.state.az.us.

[40] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2004 Medical Expenditure Panel Survey – Insurance Component. http://www.meps.ahrq.gov.

[41] St. Luke's Health Initiatives. December 2006. *Arizona Health Futures: Health Bullets.* http://www.slhi.org.

[42] Healthcare Institute at the Arizona Hospital and Healthcare Association. October 2003. *2003 Workforce Shortage Survey*. http://www.azhha.org/public/workforce/hci.

[43]Based on findings from these issue briefs, strategies such as tax credits, small employer market reform, social insurance, were eliminated as effective options for reducing the uninsured rate in Arizona.

[44] HealthCare Group – Moving Towards Accountability: A Proposed Plan. January 2001.

[45] The latter two provisions came about as part of the negotiations with the commercial insurers.

[46] U.S. Census Bureau: American FactFinder - Arizona.

[47] This is based on a 2 year average 2004 – 2005. See *Income, Poverty and Health Insurance Coverage: 2005* Current Population Reports by Carmen DeNavas-Walt, Bernadette D. Proctor and Cheryl Hill Lee from U.S. Census Bureau (Issued August 2006); available from http://www.census.gov.

[48] U.S. Census Bureau. American Community Survey Profile 2005. http://www.census.gov/acs.

[49] Ibid

[50] Ibid

[51] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2004 Medical Expenditure Panel Survey – Insurance Component. http://www.meps.ahrq.gov.

[52] Ibid.

[53] Kaiser Family Foundation. State Health Facts Online. Arizona: http://www.statehealthfacts.org.

[54] In July 2006, AHCCCS enrollments was 17% using actual AHCCCS enrollment data for July 2006 and the U.S. Census estimates for Arizona for the same period.

[55] Center for Studying Health System Change. http://www.hschange.org

[56] Current Federal Poverty Levels (1/2007) means a family of 4 at 100% of FPL earns $20,004 annually; a single individual at 100% of FPL earns $9,804 annually.